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Access and the Uninsured:

A Guide for States

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INTRODUCTION

Reflecting a growing consensus in the United States, President Bush announced in his 1991 State of the Union address that "Good health care is every American's right." But the realization of this principle continues to be elusive and how best to finance and deliver that right to every citizen remains a challenge. States have risen to the challenge and are experimenting with innovative approaches to bring appropriate and affordable health care to the more than 31 million Americans without it. These current efforts build on the historical public health role of states to prevent disease and promote health.

This Guide reflects their activity and provides, in one place, a comprehensive analysis of what states are doing to help meet our crisis in providing access for the uninsured.

The National Academy for State Health Policy, a private, non-profit forum for leading state health policy officials, is dedicated to advancing innovative solutions to pressing state health policy issues. Through a series of Guides we hope to assist other policy makers understand what activities are now under way and to provide analysis to inform new policy advances. This Guide, ***Access*** *and the Uninsured*, highlights much of the current activity in states concerning efforts to redesign financing and service delivery mechanisms to increase access to care. Such a guide cannot be all inclusive nor can it summarize every proposal currently being proposed and debated in the states. Rather, we have highlighted significant and currently operational programs and analyzed the issues states have confronted as they seek to bring about reform. That analysis provides considerable detail of the strategies states have used which we hope will assist other states in developing programs.

As evidenced here, the states have been actively engaged in system re-design. As those states and the nation face renewed and severe budgetary constraints, it is important that these innovations not be lost and that these state laboratories for health system development be encouraged, supported and monitored.

We hope this Guide will provide the means to understand and encourage such innovation and will help advance state-based initiatives to afford every citizen a right to health care.

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EXECUTIVE SUMMARY

Health care inflation, a deteriorating health system infrastructure, changing demographics, reduced federal commitments and erosion of private insurance coverage have all converged over the past two decades to create a crisis of access to care that is directly reflected in reduced health services to the poor and uninsured resulting in poor health outcomes. States have responded to this crisis in creative and multi-faceted ways, not only providing some relief to those most directly affected by financial and other barriers to care, but also creating a laboratory to test different models for re-figuring and repairing the health care delivery system.

The access problem is large and multi-faceted. Absent a simple payer system, the gaps in the country's current mixed public/private system cannot be filled with a simple, new program or expansion of existing programs.

- About half the uninsured are at or near poverty, resulting in a need for strategies that significantly lower costs or offer substantial subsidies to the low income uninsured.

- Financing alone cannot guarantee access which is further complicated by provider shortages and infrastructure problems. Further, the special needs of particular population groups such as the homeless, persons with AIDS and drug-addicted babies require the provision of targeted and enhanced health care services rather than (or in addition to) insurance coverage.

- About three-quarters of the uninsured work or are dependents of workers, making expansion of workplace coverage a priority among current activities.

- Half of uninsured workers are employed by small businesses which face high insurance costs: employee turnover, and medical underwriting barriers, highlighting the need for expanding coverage options in this sector. But a significant share work in larger firms, indicating a need for new strategies in this sector as well.

- The access problem is both driven and compounded by health care cost inflation, which continues to rise faster than general inflation and hinders states' abilities to respond adequately.

State responses to this crisis have included expansions of public health and financing programs, enhancements of delivery system networks, public/private insurance coverage partnerships and incentives to encourage private coverage. Fundamental reform of health care delivery and financing, such as enactment of a tax-funded single payor model, is complicated by powerful vested interests in the current system and uncertainty about how a

new program should look. Several states have considered but not yet approved or implemented such a model. Thus, the strategies reviewed in this report are, of necessity, limited to those that build upon the current, primarily private, employer-based system of coverage. Some of these new programs, however, involve creative partnerships between the public and private sectors and begin to blur the lines between the traditionally distinct territories of private insurance and public programs. These new state activities are summarized below.

Medicaid

The Medicaid program has been, and continues to be, an important programmatic option for meeting the health care needs of the poor and special populations. The combination of low administrative costs and services and federal matching dollars, makes Medicaid a very cost-effective choice for expanded services.

- New mandates and optional eligibility groups have substantially expanded Medicaid beyond its traditional boundaries, and, for the first time, uncoupled the program from welfare and provided some uniform income eligibility guidelines across states.

- Federally funded Medicaid demonstrations are experimenting with public/private collaborative strategies that use private carriers, match employer contributions and allow higher income groups to buy in on income-based sliding scales.

- Piggy-backing on Medicaid claims processing, provider contracting, and eligibility determination processes, some states are using state dollars to expand coverage to children, pregnant women or the disabled.

These innovations are being threatened, however, by state fiscal crises and continued health care inflation. At the same time that some states are expanding Medicaid to new populations, others are eliminating optional groups and services or reducing state-funded general assistance outlays.

Health Systems

When and if the debate about how best to finance health care is resolved, the questions remain what we expect to achieve from increased access and how to develop appropriate systems of care to meet special needs. States have been laboratories not just in experimenting with health care financing, but also in redesigning the health care infrastructure.

Service Integration and System Development

- Changing demographics and financing create new demands on existing systems. States have been actively involved in assisting acute care facilities to change to other uses and in stimulating collaboration between Medicaid and Maternal and Child Health programs to increase access to pregnant women and children and others.

  At the local level, consortia of hospitals, community health centers and agencies reorganized into formal provider networks have met with success in responding to the needs of rural, inner city and minority populations.

- Loan and scholarship programs, tax credits and supplemental payments have assisted in the recruitment and retention of health professionals in medically underserved areas as have collaborative programs between providers and Area Health Education Centers.

- States have linked innovative financing with direct service programs to better serve special populations such as substance abusers (including pregnant women) persons with AIDS and others with special needs.

Public Incentives for Purchasing Private Coverage

In an effort to stop the erosion of private insurance, states are using direct and indirect subsidies to reduce the cost of private coverage, particularly for small business employees, low-income families or children. Subsidization of workplace insurance provides an opportunity for states to share the costs of coverage with the private sector (unlike Medicaid or directly funded clinical services). However, workplace targeted strategies have limitations in resolving the access problem.

- Workplace coverage programs have not been effective in reaching part-time and seasonal workers, uninsured workers in large firms and the unemployed.

- Subsidies targeted to low income workers enrolled in their employer plans are administratively complex, requiring eligibility determination, coordination between public agencies, employers and insurers and complex billing systems.

Individual subsidy programs (not based in the workplace) appear easier to administer and market than workplace coverage programs, but are costlier if fully subsidized (requiring a 70-80 percent average subsidy compared to a 30-40 percent subsidy for employer-sponsored plans). A commonly found form of individual subsidy programs, the High Risk Pool, is currently having limited impact on the access problem because the level of subsidization is insufficient to render these plans affordable to low income individuals.

Tax Incentives

The state strategy that could most explicitly and completely expand employer-based coverage - mandated employer health coverage of all or most employees - is precluded by the federal ERISA preemption (even assuming that states could or would want to overcome political resistance to this approach). However, states' taxing power, within the constraints of federal ERISA preemptions, is being used to provide incentives for individual and employer coverage.

- "Pay or Play" laws create incentives for workplace coverage by crediting employers' health benefit costs against new payroll taxes designed to fund coverage for the uninsured. The Massachusetts law is currently under court challenge with regard to the ERISA preemption, but carefully crafted programs may survive.

- Federal tax credits for low income families who cover dependent children (OBRA-1990) and state tax credits for currently uninsured small businesses who purchase coverage, provide incentives for coverage. However, because these credits will, for the most part, provide a retroactive adjustment to the costs of coverage, their potential impact remains unclear.

Insurance Regulation Reform

There is significant public sector and private sector activity under way to reform and restructure the small group insurance market where rapid health care inflation, adverse risk selection and aggressive underwriting practices have contributed to an increasingly dysfunctional market.

- Through regulatory reform and with the participation of the insurance industry, states are moving toward strategies that will broaden access, including guaranteed renewability provisions, limits on pre-existing condition clauses, limits on the uses of medical underwriting and constraints on differential rating, both at the initial offering and at renewal.

- These reforms are being coupled with the development of reinsurance mechanisms to spread the cost of high risk cases broadly across the small group market, improve access for high needs populations, and provide protection to individual carriers.

Although these strategies move in the direction of equalizing rates among small groups, they still allow substantial variation and may not remove price barriers for many. Some states are approving "basic" benefit configurations for small groups in efforts to reduce premiums; others are considering community-rating strategies to completely equalize prices.

Because the expansion of the small group market to cover potentially high risk cases may increase average premiums and create new financial barriers, regulatory reforms may require additional price reducing strategies such as direct subsidies, indirect subsidies, or provider discounts.

Private Sector Initiatives

In some cases, the private sector has responded to the health care crisis with privately funded charity care programs and benefit modifications to make low-cost coverage options available.

- Caring Foundations, non-profit corporations funded through philanthropic donations, offer free primary care to low-income uninsured children in ten states.
- Some insurers are experimenting with insurance products that combine coverage of selected preventive services with catastrophic coverage.
- Several states have responded to the concern for low cost products with exemptions from mandated benefits for insurance for small business.

The issue of the appropriate configuration of benefits, balancing concerns for lowered premium costs with concerns for out-of-pocket expenditures that render many low and moderate income persons "underinsured" (and may discourage appropriate use of preventive and primary care services) is under active debate in many states. Some states, rather than providing an across-the-board exemption to mandated benefits, have reconfigured a minimum benefit package that includes some coverage of preventive services (e.g., prenatal care well-child visits and standard cancer screens) with coverage of catastrophic health care costs.

Comprehensive Access Strategies

The states that have adopted broad initiatives to cover most of their residents are providing laboratories to test different models of health care financing and delivery. No state has yet undertaken a universal, single payor system, but rather, states continue to rely on employer-provided coverage combined with public programs, subsidies, tax incentives and regulation. Although significantly expanding access to care, these systems may continue to have groups who "fall through the cracks".

- The emphasis on insurance may leave hard to reach populations in underserved areas without access.
- Workplace strategies may not significantly expand coverage for part-time or seasonal workers.

- The cost of coverage in the small group market, despite reforms, may require a level of subsidy that states are not fiscally or politically prepared to provide.

In the context of these limitations and the current economic recession, cost containment strategies are vitally important to the resolution of the health care crisis.

These state efforts are leading the way in meeting a pressing social need, in advancing the state of the art in cost containment strategies, and in developing models of potential national interest for assuring appropriate access to care.

Chapter I The Current Context for State Actions

The Scope of the Problem

The problem of access to care viewed at the national level is now familiar and widely cited. In a society that has chosen health insurance coverage as its principal vehicle for assuring access to health services, there are at least 31 million people, or 13 percent of the non-aged population, without any coverage. The problem worsened significantly during the recession of the late 1970s and early 1980s and has held constant during the latter half of the decade despite a substantial economic recovery,[1] The trend toward lack of coverage has had a substantial and sobering impact on access to care for the poor and the uninsured. In 1986, 31 percent of the uninsured reported having no regular source of care, as compared to 16 percent of the insured (Robert Wood Johnson Foundation, 1987). The average number of physician visits for the low income in fair or poor health declined by eight percent between 1982 and 1986, compared to a 42 percent increase for the non-poor with similar health status (Freeman, et al., 1987). While the uninsured include a higher proportion of persons in fair or poor health (12 percent in 1986, compared to nine percent of the insured), the uninsured had 27 percent fewer physician visits than the insured - a gap that had widened from 19 percent in 1982 (Freeman, et al., 1987). These statistics have been recognized by both federal and state policy makers as a call to action.

The health care issue has moved to the front of state policy agendas, not just because politicians and analysts watch the trends with increasing alarm, but also because the growing number of uninsured persons, coupled with run-away health cost inflation, is placing significant strains on the health care delivery system.

- Stresses have appeared in the hospital system, which in many communities has been the first and only source of care for the poor. Public funds that have traditionally supported hospital charity care have been curtailed at the same time that major third party payors have become increasingly resistant to absorbing these costs. Most significant in this regard is the Medicare Program's non-participation in covering a hospital's bad debt or charity care expenses.

- Rural and poor inner-city areas continue to be hampered by shortages of providers and an eroding health system infrastructure.

'The 1987 National Medical Expenditure Survey produced estimates that 37 million persons, or 17.4 percent of the non-aged population were uninsured. Similarly, the 1987 Current Population Survey (CPS) indicated that approximately 37 million lacked coverage. The 1988 CPS, however,due to conflicting answers to different questions of insurance status by a substantial number of participants, has produced estimates ranging from 3 1 million to 35 million. It is not clear whether the difference between 1987 and 1988 data reflect an actual decline in the number of uninsured persons, over-estimates in 1987, or under-estimates in 1988 (See Swartz, 1989).

- Employer benefit coverage has begun to erode. Rising costs are causing employers to shift more and more of the health benefit costs to employees, frequently resulting in the loss of coverage to employee dependents.

- Finally, stresses have become evident at the national level, where sequential cuts in federal contributions are straining states' ability to finance services to even their most vulnerable residents at the same time that the federal government has increased mandates for coverage of poor women and infants, resulting in a call from the governors for a stop to costly, new mandates.

Employers and union organizations - traditionally the providers of most health insurance coverage in the country - hospitals, doctors, insurers and the public have all been stimulated to call for changes. The difficulty that states face is, of course, that the access problem is neither uni-dimensional nor amenable to easy solutions. There are several angles from which to approach the issue, each of which reveals a different facet of the problem and lends itself to a different set of strategies or solutions.

Access and Poverty

Access barriers can be examined first as an issue of income. As stands to reason, given the cost of health care coverage, the poor and near poor are at much greater risk of being uninsured than higher income populations (Table 1). 1987 data show that approximately 32 percent of the uninsured lived in families below the federal poverty line, and nearly half below 150 percent of this level (Swartz, 1989).

Although little is known about health coverage price elasticity among the low-income, one multi-state analysis of family income and expenses found that families with incomes below about 250 percent of the poverty line have no discretionary income to contribute to insurance premiums*. However, a Washington State survey of the willingness of families with incomes under 225 percent of the poverty line to contribute to insurance premiums found that even people with incomes below poverty said they would be willing to pay about 3 percent of their gross income for health insurance, with higher income families reporting that they could pay 3 to 4 percent.[3] A newer Massachusetts survey found that over three quarters of the uninsured (42 percent of whom had incomes below 200 percent of poverty) expressed willingness to purchase family coverage at costs ranging from $85 to $235 per month (Blendon, et.al., 1990).

[2]The Affordability of Health Care for Working Families reports were prepared on a state-specific basis by the National Health Care Campaign and Citizen Action and are currently available through the Families USA Foundation, Washington, D.C.

[3]In practice, the Washington Basic Health Plan has found that even those with incomes below 75 percent of poverty are willing to contribute a small amount ($7.50 per month) towards their health care.

The association between income and uninsured status suggests strategies at the state level to expand eligibility to entitlement programs or to subsidize, perhaps on a sliding scale, the purchase of coverage for the poor and near poor who are not eligible for Medicaid. Many states are pursuing precisely these goals (see Chapter II for Medicaid and Medicaid-like expansions, and Chapter IV for subsidized private coverage programs).

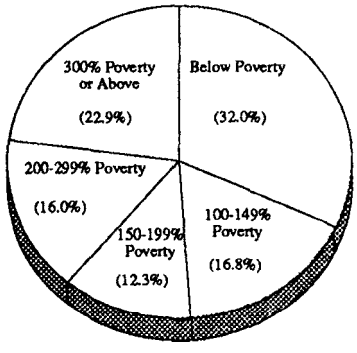
However, a close examination of the uninsured population reveals that the group does not fit the mold of traditional entitlement programs; and a focus on income eligibility alone can both leave a significant portion of the problem untouched and also cause a collision between the traditionally distinct territories of public coverage programs and private sector coverage.

Table 1
Insurance Status of the Non-elderly Population by Family Income

Family Income	Percent Uninsured
Below Poverty	38.4
Poverty to 149% Poverty	35.1
150% to 199% Poverty	23.5
200% to 299% Poverty	14.8
300% Poverty or Above	8.3

Source: 1987 CPS; Swartz

Figure 1
Distribution of the Non-elderly Uninsured by Family Income



Source: 1987 CPS; Swartz

Access and Work Status

Unlike traditional Medicaid recipients who, for the most part, are either in unemployed single parent homes or elderly or disabled, most of the currently uninsured population have some attachment to the workforce. Data from 1987 indicate that 76.9 percent of all non-aged uninsured persons were in households with at least one employed family member, 46.2 percent where the work was full time[4]. Thus, while employment clearly provides insurance for most of the working population **(64.3** percent of the total population has employer or union provided health insurance), it does not guarantee coverage. The proportion of uninsured workers varies among states and depends upon the state's general

[4]These figures and others cited throughout this chapter, unless otherwise indicated, are from Short, Monheit, Beauregard, 1989, A Profile of Uninsured Americans, based on data from the 1987 National Medical Expenditure Survey.

economy. But, in all states at least two-thirds of uninsured adults are in the workforce (Bartlett and Carroll, 1990).

There are a number of factors that affect the likelihood of obtaining coverage through the work place. While 81.7 percent of full-time workers have insurance, only 62 percent of part-timers and 54.3 percent of the self-employed are covered. Coverage varies by industry, as well. As might be expected, industries where the work is frequently seasonal, unskilled or more likely to be non-unionized have much lower rates of employer provided benefits than others. Agriculture, construction, sales, and many service industries such as repairs and entertainment all show low levels of coverage among their employees.

Perhaps the most important factor with regard to work place that affects the availability of health benefits is business size. Over one fourth of the employees of establishments with fewer than ten workers were uninsured in 1987; and these persons and their dependents made up about one third of the non-aged uninsured population (Table 2 and Figure 2).

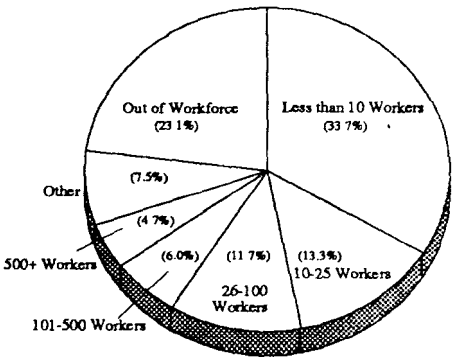
National data indicate that in 1989, fewer than half the firms of twenty or fewer employees offered health benefits to any of their employees. Among businesses with five or fewer workers, 39 percent offered coverage to some employees and only 21 percent offered coverage to all employees (see Table 3) (Hall and Kudor, 1990). These findings were corroborated by a national survey conducted by the Health Insurance Association of America that found a steep drop off in the number of firms offering coverage as size decreased. Among firms of five or fewer employees, approximately one-quarter offered health benefits (HIAA, 1990). Not all employees in firms without benefit plans remain uninsured, of course. They may obtain coverage through an insured family member or obtain coverage on their own. Nevertheless, in 1987, workers in firms of under twenty-five were more than three times as likely as those in firms of greater than 100 to be uninsured (Table 2).

Table 2
Insurance Status of Non-aged Population by Adult Family Member's Workplace

Size of Establishment	Percent Uninsured
Less than 10 Workers	26.3
10 to 25 Workers	17.8
26 to 100 Workers	12.3
101 to 500 Workers	7.1
More than 500 Workers	6.1

Source: 1987 NMES, Short, Monheit, Beauregard

Figure 2
Distribution of Non-aged Uninsured, by Working Family Member's Size of Business



Source: 1987 NMES, Short, Monheit, Beauregard

Table 3

Availability of Employer-Sponsored Health Insurance by Business Size, 1989

	Percent of Business by Total Employees				
Sponsor Health Plan for:	**<5**	**5-9**	**10-19**	**20-50**	**50+**
All Employees	21.2	36.8	47.9	59.5	63.4
Some Employees	17.4	31.0	31.6	27.7	28.7
None	57.5	29.1	17.7	10.2	5.0
No Answer	4.0	3.0	2.8	2.6	3.0
	100.0	100.0	100.0	100.0	100.0

Source: NFIB Survey, Hall and Kudor[5]

There are many factors that contribute to the low rate of health benefits coverage among small businesses. When surveyed, the owners of these establishments overwhelmingly point to the cost of coverage as being the barrier to their offering insurance (Hall and Kudor, 1990; HIAA, 1990; Marine and Glazner, 1988; Formisano, 1988). Comparatively high overhead rates and low profit margins may put an insurance plan out of reach for many. But because of high insurer administrative costs and poor claims experience in the small group market, small business owners with a similar workforce (ie: employees with the same age and sex distribution), pay more than large businesses for the same level of benefits. Small businesses pay between 110 and 140 percent of what large businesses pay for comparable benefits (U.S.,GAO, 1990). Additional factors that may discourage insurance coverage among small businesses are high employee turnover, seasonality of work, or high fluctuations in monthly cash flow.

The small business sector's disproportionate share of uninsured workers and the growing awareness on the part of policy makers of the barriers faced by small business owners have led many states to consider strategies to expand access to care in this economic sector. Many of these strategies are discussed in Chapters IV, V, and VI.

However, an exclusive focus on small business leaves unaddressed a substantial part of the problem. Half of uninsured workers and 23 percent of the total non-aged uninsured population are connected to firms with more than 25 workers. Another 23 percent of the uninsured are out of the work-force (Table 2, Figure 2).

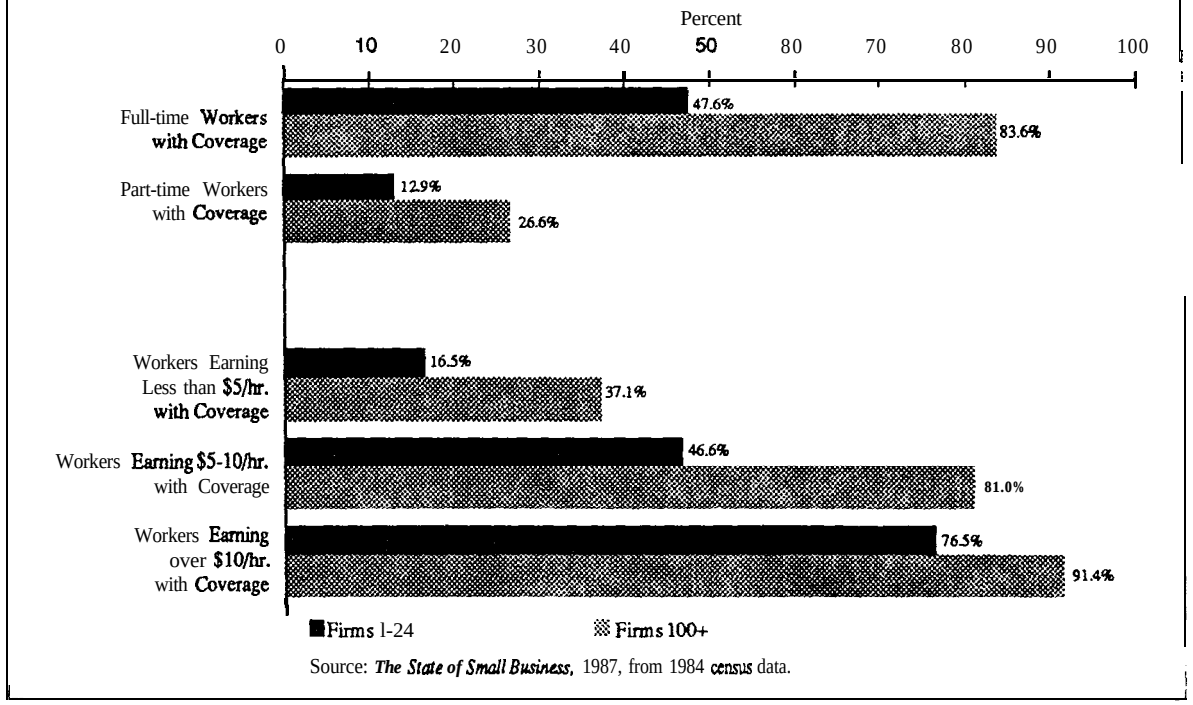
'This survey included only member businesses in the National Federation of Independent Businesses and may, therefore, be less broadly representative than the HIAA survey cited in the text. However, these surveys and most others are very consistent with regard to findings on the relationship between business size and insurance status.

The Compound Effect of Income and Place of Employment

The factors of income and place of employment act alone and in conjunction to contribute to the problem of the uninsured. These dynamics are well illustrated in Figure **3** below, which shows that the percent of the working population covered rises dramatically as the wage rate increases. Yet at every wage level, more workers in large businesses have

Figure 3

Comparison of Health Coverage in Small and Large **Firms by Characteristics of the Workforce**



Source: *The State of Small Business,* 1987, from 1984 census data.

coverage than those in small businesses. It is important to note, nonetheless, that in 1984, among workers earning less than $5.00 per hour in large businesses, only 37 percent had health insurance coverage.

Demographic Factors

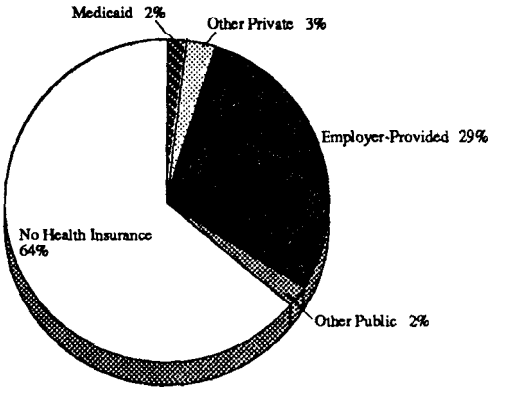
Strategies to address the problem of the uninsured must also take into consideration the basic demographic make-up of the target population. Of significance is the factor of age. Almost one third of the uninsured are below the age of nineteen and another nineteen percent are between the ages of nineteen and twenty-five. Lack of coverage is particularly dramatic among this young adult population. Over 30 percent of all persons in this age group in the country are uninsured. The especially pronounced gaps in insurance among children and young adults are related to the dominant method of coverage available to young people - as dependents on a parent's policy. Young adults "age out" of eligibility for coverage as a dependent, somewhere between the ages of 18 and 22, depending on their residential and

occupational status. Many face an interim period - in entry level jobs, before entering the workforce, or as students - when group coverage is not available to them and when they may be disinclined to purchase individual coverage because they do not anticipate needing health services.

Young children must generally rely on their parents for coverage, and this coverage may be either unavailable or financially out of reach for the parent - even when the parent has insurance for him or herself. Among uninsured children in 1986, 36 percent were in homes where the family head had health coverage (Figure 4).

Figure 4

Children Without Health Insurance by Family Head's Source of Insurance



Source: EBRI tabulations of March 1986 CPS

The problem of access to appropriate health care for children has received wide-spread attention and inspired both a commitment of resources and new program development in the public sector (see Chapter II for children's Medicaid expansions and buy-ins, and Chapter III for direct service enhancements for children), as well as initiatives in the private sector (see Chapter VII).

A final factor of significance to policy makers is the racial and ethnic distribution of the uninsured. While 12 percent of whites are uninsured, 22 percent of blacks and 32 percent of Hispanics lack insurance coverage. To a certain extent, these differences mirror the work place situations of these populations, where close to 70 percent of whites have employer-provided coverage, compared to 48.5 percent for blacks and 46 percent for Hispanics. However, lack of coverage among Hispanics is especially pronounced even when adjustments are made for income and employment. Between 1986 and 1988, over half (52 percent) of persons of Hispanic origin spent some time uninsured, compared to 26 percent of whites and 38 percent of blacks (Nelson and Short, 1990). This relationship is not well understood, but may point to the need for targeted efforts encompassing bi-lingual delivery systems in states with large Hispanic communities.

Lack of financial coverage for health care can frequently be compounded by a lack of providers in poor, minority neighborhoods. The rise in the number of uninsured is putting pressure on publicly funded hospitals and health centers that have traditionally provided free or sliding-scale care. Medical schools continue to turn out a disproportionate number of specialty physicians in relation to the need for primary care services, and physicians continue to concentrate their practices in financially well-off areas near major teaching institutions and medical centers, leaving poor and rural areas underserved. On top of these trends, a number of problems have arisen requiring specialized services. The AIDS epidemic has created new and serious demands for acute inpatient care, long term care, and health education. Crack and cocaine use is devastating the health and lives, not only of the direct users, but of their offspring, born with addictions and frequently with other serious complications, as well. The huge increase in the homeless, including among their numbers many persons deinstitutionalized from mental health centers, has created new challenges for public health officials. The combination of factors affecting access in these situations may lead states to consider strategies combining direct services with innovative funding mechanisms and focused outreach efforts (see Chapter III).

Underinsurance

The problems associated with insurance coverage are further complicated by underinsurance - situations where insurance coverage is inadequate and the individual or family does not have the means to absorb the required out-of-pocket expenditures. Measurement of this problem is difficult, but a credible analysis of this issue in 1984 indicated that the problem is significant and wide-spread (Parley, 1984). The analyst defined being "underinsured" as having a one in one hundred chance of incurring medical expenses that would exceed 10 percent or more of the family income - beyond what was covered through insurance. Using this definition, she determined that 13 percent of the non-aged population was under-insured. Perhaps more significantly, among persons with individual as opposed to group coverage (10 percent of the non-elderly, privately insured), 52 percent were underinsured.

Underinsurance can result from gaps in coverage at either "end" of the health care needs spectrum. Individuals can face catastrophic costs if their policy places an upper limit on the number of hospital days covered or a maximum payout of benefits. Conversely, if the policy requires substantial out-of-pocket expenditures prior to insurance coverage, or precludes coverage of major categories of services (eg: preventive care or non-hospital-based care), individuals may face "front end" costs they are ill-equipped to afford for routine medical services.

While the 1984 study showed underinsurance to be an issue primarily of those with non-group coverage, the problem may be spreading more broadly. U.S. Bureau of Labor Statistics data show that, during the 1980s, employee cost-sharing in premiums escalated faster than the rate of medical care inflation. The proportion of workers required to pay part of individual coverage rose from 21 percent to 46 percent between 1982 and 1988, and for

family coverage, the proportion rose from 51 percent to 65 percent in this same time frame. Taking into account both the increased percentage of health benefit plans requiring premium cost-sharing and the increasing dollar amount of the employee contribution, average per capita employee premium costs rose from $31 to $72 in individual coverage, and from $171 to $320 for family coverage during this four year period. These premium increases, in combination with increasing deductibles and co-insurance that rises in proportion to medical costs, have resulted in aggregate out-of-pocket expenditures that are rising faster than medical care prices in the 1980s (Short, 1988).

It is, of course, lower income families who are at greater risk of underinsurance because they have less discretionary income. As Table 4 indicates, in 1987, more than a third of families below the federal poverty line had out-of-pocket medical expenses in excess of 5 percent of their income, compared to only three percent of high income families. Greater than 15 percent of families in poverty had expenses greater than 25 percent of their income, compared to one tenth of a percent of high income families (DHHS, 1987).

Table 4

Percent of Families Experiencing Out-of-Pocket Expenditures Above Income Related Thresholds, by Threshold and Income Status, 1987

	Out-of-Pocket Expenditures in Excess of the Following Percentages of Family Income		
	5%	15%	25%
Percent of All Families	15.3	5.9	3.7
Percent of Families by Income Status:			
Poor (< 100% of Poverty)	35.1	20.9	15.9
Low (loo-200%)	26.1	9.1	4.1
Middle (200-400%)	11.2	2.4	1.1
High (400% +)	2.9	.4	.1

Source: DHHS, Office of Health Policy, 1980 NMCUES.

The issue of underinsurance is not currently being addressed through explicit programmatic efforts at the state level. It figures significantly, however, in debates that are very active at the state level over mandated benefits (see Chapter **VII)** and over the benefit configuration for new state programs discussed throughout this guide. **At** issue is how much society is willing to spend, how to get good value for those dollars, and how best to use limited resources. Is some coverage, even if limited, across a broader population a better choice than comprehensive coverage for a more targeted group? If the choice is made to offer limited coverage, further consideration must go into setting priorities among services.

These issues are being confronted most explicitly in Oregon's proposed Medicaid Program and state-funded program for the poor (see Chapters IV and VIII).

Health Care Costs

The access problem is both being driven by and compounded by rapid and poorly controlled health care expenditure inflation. Again, the basic parameters of the problem are well known and widely cited. The United States, while standing almost alone among industrialized nations in not having some sort of universal health coverage or health service program, nevertheless, leads all nations in average per capita health care expenditures and health care expenditures as a percent of gross national product (Schieber and Poullier, 1989).

Health care costs exploded over the past two decades in ways that have dramatically affected both the public and private health coverage systems. National health care expenditures were $9.9 billion in 1970, rose to $33.2 billion in 1980, and more than doubled again, to $69.6 billion in 1988 (HIAA, 1990). Medicare payments in that same eighteen year time frame, rose from $6.8 million to $85.5 million; and Medicaid payments, from $6.3 million to $48.7 million.

There are many causes associated with the dramatic growth in health care costs. General inflation accounted for 32 percent of the increase in 1988. People are seeing providers more frequently and for a broader variety of ailments, driving up the volume of services. This increase in the intensity of service use is strongly related to the aging of the population and the "technological revolution" in health care. As more and more people survive the acute illnesses and traumatic injuries that can cause premature death, they live to experience more of the chronic ailments and illnesses that can beset old age. These conditions frequently require ongoing medical care, and as medical interventions become more sophisticated, may be extended over a longer period. Changes in utilization and the aging of the population accounted for about 35 percent of the increase in health care expenditures in 1988.

The new technological diagnostic procedures and interventions, which sometimes have the capacity to significantly prolong or improve the quality of life, are, of course, in frequent demand in situations where the potential exists, sometimes only slight, for benefiting the patient; and no effective mechanisms have been developed to control the proliferation of these technologies. As a labor intensive industry, the health sector was hard hit by cost increases brought about by unionization and wage increases of semi-skilled and skilled work forces in the 1970s. Medical price increases accounted for 22 percent of total health care inflation in 1988 (Meyer, et al., 1990).

The high cost of health care significantly affects the policy process in the design and implementation of strategies for the uninsured. Obviously, the expansion of coverage to new populations requires a considerable financial commitment. But this is not the only issue. The ongoing increases in health care costs create a dynamic situation, where policy makers find themselves shooting at a moving target. Even while public initiatives extend coverage to

those already identified as uninsured, the ranks of the uninsured are being replenished by those dropping from the private coverage system. Rising costs are forcing employers and individuals to reduce or drop coverage, and, in some instances, insurers to leave the market as well.

Clearly, the issue of health care cost increases needs to be addressed simultaneously with the access issue. While the discussion of explicit cost containment strategies in this report is limited (see Chapter VIII) the concerns for this issue can be seen in the choices made by states for health care delivery systems that incorporate cost containment measures and in the strategies to share costs across the public and private sectors (see Chapter IV, particularly). Cost containment is and should be a state objective. To date, however, the search for the perfect cost containment strategy has not deterred state action on the critical issue of improving access to health care for the most needy citizens.

Summary and Conclusion

The problem of lack of coverage arises from many causes and manifests itself in complex, multi-faceted ways. States can choose to focus on a particularly acute aspect of the problem or to tackle it more globally. A global strategy can take the form of a totally public financed and universally available program such as exists in Canada and has been proposed, but not enacted in several states (Colorado, Illinois, Michigan, Ohio and Washington). None of these proposals has reached the point of implementation, and they are not described in detail in this report. Alternatively, states can attempt comprehensive interventions that build on the existing framework of employment-based coverage and public programs for those out of the workforce. Such interventions, to achieve universal access, must of necessity involve multiple strategies. The broad distribution of the uninsured across demographic groups and economic sectors, precludes filling the gaps in our current system with a simple, unitary program. Such strategies provide the option of approaching the access problem incrementally, targeting public dollars to high priority populations such as pregnant women and children.

To date, state strategies have included a limited number of efforts to achieve global access through multiple coordinated initiatives built on the current insurance framework (discussed in Chapter VIII), and a multitude of incremental programs. These strategies, encompassing expansions of public programs, public/private partnerships and the stimulation of private sector solutions through incentives or regulatory constraints, are discussed in the balance of this report.

Chapter II Expansion of Public Entitlement Programs

Introduction

The Medicaid Program has long been the largest, most comprehensive, and most broad based public program of funding for health care services at the state level. As such, it is natural for both the states and federal policy makers to turn to the Medicaid program first, when considering new public commitments for health coverage for the uninsured.

In fiscal terms, the Medicaid program may offer states the most cost-effective means of providing care to medically indigent populations. Its costs per service are low, both because provider reimbursement rates are below community charge levels and also because the Medicaid program brings with it already developed administrative mechanisms for eligibility determination, claims processing, provider rate setting and regulatory oversight of the health care delivery system. For states that have not yet adopted all optional eligibility groups, Medicaid expansion is a logical first step for a state to consider in addressing the uninsured problem, because expenditures under this program are matched with federal dollars (sometimes quite favorably), significantly reducing required state outlays.

Nevertheless, Medicaid imposes limitations that curtail both programmatic options and target populations in ways that may not fit a given state's requirements for addressing the access problem. Federal Medicaid rules limit eligibility not only by income level, but also categorically, excluding from coverage, for example, young single adults (unless disabled), regardless of income. As federal policy makers have acted to incrementally expand Medicaid entitlement, eligibility has become increasingly fragmented. States that have taken advantage of optional groups; have upwards of forty different eligibility categories to contend with. This situation not only creates confusion among potentially eligible clients, but also results in a large administrative burden for the states. Further, because states can discretionarily set the income eligibility guidelines for their income assistance and Medicaid programs, eligibility is different in every state, ranging from a low of 24 percent of the federal poverty level in Alabama to a high of 95 percent of the federal poverty level in Utah (Congressional Research Service, 1988). These variations, governed by local political climates and regional economics, create geographic inequities and inconsistent resource allocation to health care services. National proposals have periodically surfaced, but have not yet been adopted, to simplify Medicaid eligibility requirements by adopting a universal income standard and divorcing Medicaid eligibility from welfare programs.

Even if adopted, such changes would not do away with the "revolving door" eligibility problem that plagues the Medicaid program. As long as eligibility is tied to a non-flexible income level, individuals and families whose income hovers near that level are likely to pass back and forth through periods of eligibility and non-eligibility - creating added administrative complications for the program and hardship for these families, for whom marginally higher income often does not confer access to health coverage or ability to pay

for care. Persons who have left the Medicaid program have been shown to be three times as likely as the general population to lack health coverage. About half (48 percent) of those who left in 1980, and who did not regain eligibility for Medicaid, were still uninsured 12 months later (Nelson and Short, 1990).

Another issue that states must consider in weighing the pros and cons of Medicaid expansions is the access barriers that many Medicaid recipients face due to reluctance on the part of providers to serve them. Historically, in many states, Medicaid rates of reimbursement have been below usual charges, and in some cases, below costs. Particularly in the area of obstetrical care, where malpractice costs have sky-rocketed, provider participation rates dropped. Many states are responding to the situation by raising rates, either selectively for particular problem areas like obstetrical care, or, in a few instances, across the board using relative value scale fee adjustments.' Fee changes were accelerated in 1990 by federally mandated (OBRA-89) standards for obstetrical and pediatric reimbursement that attempt to establish equal access for Medicaid recipients. States are required to submit data to HCFA that proves compliance by one of three different tests.* As of August, 1990, 23 states had received approval of their plan amendments, encompassing these standards (NGA, 1990).

OBRA-89 Medicaid changes also include a requirement that community health centers be paid costs, based on Medicare cost reimbursement rules. Thus, the situation with regard to Medicaid provider reimbursement rates is far from static. Nevertheless, states with Medicaid reimbursement rates below community reimbursement standards must weigh the cost-savings associated with using Medicaid's fee structure for expanded coverage of newly eligible populations against the potential barriers to access associated with low Medicaid reimbursement.

Finally, states must consider the advantages and disadvantages of creating publicly funded entitlement programs that forego any employer contribution toward coverage costs. As discussed in Chapter I, over 70 percent of the uninsured have some attachment to the work place. Medicaid-like programs allow the targeting of public subsidies to the lowest income in this population, but do not lend themselves easily to employer support. As discussed in greater depth in Chapter IV, even though it reduces public outlays for health care coverage, subsidizing work place-based coverage is administratively complex and complicates targeting the low-income population.

'Maine has implemented relative value scale fee changes and Michigan has a similar fee revision under development.

[2]These tests are: (1) A 50 percent participation rate among obstetrical and pediatric providers, within every county or geographic region, or Medicaid participation equal to Blue Shield participation; (2) Payment rates equal to or greater than 90 percent of usual and customary rates, including patient co-insurance; or (3) Other documentation of equal access including, but not limited to, studies of utilization and recipient surveys.

Over the past several years, Congress has substantially expanded both mandatory and optional eligibility categories bringing, for the first time, some uniformity to income eligibility guidelines and starting the process of uncoupling Medicaid from welfare programs. These changes have, to date, been limited to certain particularly vulnerable groups like infants and pregnant women. In addition, Congress has authorized a series of state demonstrations that test new eligibility categories and sliding scale premium payments to permit persons with slightly higher incomes to enroll in Medicaid. Beyond this, states have acted on their own, without federal matching funds, to "piggy-back" access programs on Medicaid, using state-established eligibility criteria and state funds. These federally-sponsored and state-initiated changes to the Medicaid program are discussed below.

Medicaid Expansions and Changes

New Eligibility Criteria

Driven primarily by concern in Congress for the health of infants and children, the last several years have seen rapid expansions in both mandatory and optional eligibility categories for Medicaid. The improvement in infant mortality rates seen over the past several decades has apparently stalled, and the gap between rates for blacks and whites has not only remained distressingly large, but actually widened. Faced with convincing evidence that appropriate prenatal care can help prevent high risk and low birth weight babies, Congress moved to increase access for pregnant women and young children. Effective in 1990, Medicaid coverage became mandatory for pregnant women and children below age six whose household income was below 133 percent of the federal poverty level. Children in families with incomes below poverty up to age eight have also been made eligible without regard to categorical criteria, and those through age 18 will be phased in over the next twelve years. Starting in 1988, states also obtained the option to cover pregnant women and infants up to 185 percent of the federal poverty level. In addition, states were given the option of using presumptive eligibility for pregnant women and removing assets tests for pregnant women and children. Eligibility has also been extended to the elderly and disabled with incomes up to the federal poverty level.

Medicaid Demonstration Projects

In 1990, Congress authorized three Medicaid demonstration projects to extend eligibility, without regard to categorical requirements, to otherwise uninsured pregnant women and children up to age twenty below 185 percent of the poverty line. The federal authorization requires the participating states to impose sliding scale premium contributions for those above the poverty level, but prohibits contributions more than three percent of household income. Foreshadowing the OBRA 1990 requirement that Medicaid programs pay premiums and cost sharing for private group coverage when it is cost-effective to do so (see discussion, Chapter IV), these demonstrations also permit coordination with private, employer-based coverage. In 1991, Congress is authorizing a second, similar round of demonstrations, this time

extending eligibility to all persons, regardless of age or category, below 150 percent of the poverty line.

These demonstrations mark several departures for the Medicaid program. The use of sliding scale contributions for people in slightly higher income categories explores strategies that move Medicaid away from the "all or nothing" coverage approach that has resulted in rapid eligibility turnover. The use of non-traditional coverage options (excluding inpatient care, for example) by states with rich Medicaid benefits offers "compromise" coverage extending needed preventive and primary care services to broad population groups at low cost to the states. Further, these demonstrations mark new precedents in developing links to private sector coverage. To date, Medicaid programs in many states have been able to offer their recipients the choice (or, in some cases, the requirement) of enrollment in HMOs, a private sector health coverage option shared by many employer groups. In addition, several states **(California, Minnesota, New York)** have been enrolling Medicaid recipients in employment-based private insurance plans, when a review of the recipients' likely use of health services indicates that it is cost-effective to do so (see description of Medicaid "buy out" plans, Chapter IV). The new demonstrations differ in that indemnity insurers are being used to enroll recipients without regard to health status and that plans are being developed that merge Medicaid populations with other, somewhat higher income groups.

In the first round of demonstrations, awards were granted to Florida, Maine and Michigan, whose programs are described below. A request for proposals for the second round of demonstrations had not yet been issued when this report went to publication.

Florida

Florida is using the demonstration authority to set up a program. of health coverage for children, organized around the school system. In this program, children will be subscribers for an insurance plan, administered by an insurer or HMO and underwritten by the state Medicaid agency. All school children within the demonstration school districts up to age twenty will be eligible to join, as will their siblings and dependents (in the case of teen parents). Parents and other family members will not be eligible. For children up to 133 percent of the federal poverty level, the premiums will be fully subsidized by the state; for those between 133 percent and 185 percent, the state will pay 72 percent of the premium. Those with incomes above this level can join at cost. These eligibility categories duplicate the eligibility criteria for the school lunch program, allowing a single determination process for both programs.

The program, called the **Healthy Kids Corporation** (HKC), offers two coverage options. A primary care services package covers all visits to primary care providers including screening exams, and routine, office-based lab tests. Children will be required to select a primary care physician who will provide or authorize all services. A comprehensive package adds specialty visits, diagnostic testing, outpatient surgery, limited outpatient mental health, and inpatient services. Prescription drugs at $3.00 per prescription,

glasses and hearing aids are available through Medicaid approved purchasing programs. Organ transplants are not covered. Mental health visits require copayments and there is a $25.00 copayment for emergency room use which is waived for true emergencies. There is no hospital deductible.

School children can elect to have the primary care package only, or the combined primary care and comprehensive package. Non-school-aged siblings and dependents are only eligible for the primary care package.

The program is being implemented and administered by a not-for-profit corporation, authorized and funded by the state legislature ($87,000 for first year administrative expenses). This corporation which was founded expressly for the purpose of operating the Healthy Kids program, reports to a Board jointly appointed by the Governor, the Insurance Commissioner and the Education Commissioner. The Board includes representatives of provider groups, the Department of Education, the Medicaid agency, and other similarly interested parties.

The program is scheduled for implementation in September, 1991 in Voulousa County. It is currently seeking a commercial underwriter for the portion of the program serving children whose income is above Medicaid eligible levels. Seven thousand children are targeted for enrollment during the demonstration phase of the program.

Michigan

Michigan's demonstration encompasses a collaboration between the state's Medicaid agency and Blue Cross Blue Shield of Michigan. Under the auspices of this public/private partnership, Blue Cross Blue Shield is developing a Caring Foundation Plan (discussed generically in Chapter VII) to provide coverage to uninsured children under age 18 with incomes up to 185 percent of the federal poverty level. The program will be statewide and, if fully funded, will serve between 14,000 and 15,000 children.

All eligible children in a family will be enrolled simultaneously. The plan covers non-inpatient services, including well-child care. Prescription drugs are covered in full without co-payment. Outpatient substance abuse treatment is covered as well.

Eligible children enroll without premium payment and there is no cost-sharing. Providers are reimbursed at Blue Cross Blue Shield rate schedules. The projected medical services cost of the program is an average of $29.50 per child, per month.

Under the terms of the demonstration, because this program is administered under the umbrella of the Medicaid agency, both state dollars and private donations for the program will be federally matched. Blue Cross Blue Shield of Michigan is contributing $800,000 to fully support the administration of the program, and is undertaking a major fund-raising campaign in collaboration with the state, in which they anticipate generating $1.5

million or more in private donations over the three years of the demonstration. The dollars available to the program will be approximately doubled through federal matching funds.

Enrollment is expected to begin in June, 1991, for a July, 1991 start-up date.

Maine

The Maine demonstration is encompassed within a larger state funded and authorized Medicaid buy-in program. This initiative, called The Maine Health Program, has extended eligibility for coverage, very similar to Medicaid coverage, for all adults below 95 percent of the federal poverty level and all children under age eighteen up to 125 percent of the poverty level. Once qualified and enrolled, children and families whose income rises above the eligibility threshold, will remain eligible for up to two years, unless their income rises to more than 150 percent of its level at the time of enrollment. Thus, the program may eventually include those with incomes as high as 180 percent of poverty.

Benefits include all covered Medicaid benefits (which in Maine, are extensive), except prenatal care and long term care. Prenatal care services are omitted because any pregnant woman within the program's income eligibility range will automatically be eligible for Medicaid and will receive benefits through that program.

There are two coverage options under the Maine Health Program. Some individuals and families will receive a card that entitles them to services in the traditional Medicaid manner. Choice of provider is unlimited, and providers bill the Medicaid program and are reimbursed at Medicaid rates. Maine accompanied the implementation of this program with an adjustment in provider reimbursement rates, applicable to both the Medicaid program and the Maine Health Program. Using a relative value scale fee adjustment, the bulk of the upward adjustment will go to primary care providers. The hope is that the enhanced reimbursement rates will increase provider participation in the program simultaneously with the substantially increased demand for Medicaid providers generated by the new program.

The second approach is a "buy-out" that provides coverage through employer-based group plans. In instances where employed eligibles have group coverage available to them, the Medicaid program determines whether paying the premiums and cost-sharing for that plan would be a cost-effective alternative to enrollment in Medicaid. For those participating in the buy-out, the Medicaid program is used as "wraparound" coverage for such services as prescription drugs that are normally not covered under private insurance plans so that coverage is equivalent to that available through Medicaid.

The determination of cost-effectiveness in Maine's program is based primarily on the level of employer contribution toward the premium. Although the program has no

authority to require employer participation, the buy-out is only available in instances where the employer's contribution compensates for the higher per benefit cost of private coverage usually associated with higher provider reimbursement rates and higher insurer overhead.

The Maine Medicaid program decided not to consider health status in determining cost-effectiveness of alternative coverage. Feeling both that the agency did not have the capacity to make accurate "medical underwriting" decisions and that the purpose of coordinating with private sector coverage should not be to shift high risk cases to other carriers, the program determined to measure cost-effectiveness, blind to health status measures, and to assume an average distribution of healthy and unhealthy individuals within the buy-out program. In this regard, the Maine program differs from other buy-out programs such as those in New York and Minnesota where cost effectiveness is measured against expected use of health services, and those targeted to particular illness categories, such as AIDS patients (See description, Chapter IV).

Through the federal demonstration authority, Maine is receiving federal matching funds for coverage of children, up to age eighteen enrolled in this program. (The coverage of adults is a state general fund expense.) Since the program opened in October 1990, over 10,500 individuals have been enrolled, with a ratio of about two adults to every child.[3] At the current time, the continued enrollment of adults is in serious jeopardy due to a state fiscal crisis, brought about by a substantial slowing of the economy in the Northeast.

In summary, these demonstrations offer new flexibility to states in configuring coverage arrangements for the poor through options that are not now generally available under Medicaid. They may, however, foreshadow the direction of Medicaid nationally. It is too early to evaluate the feasibility or success of the new models being tried. Ease of administration and uniformity of program operations are being traded for flexibility in eligibility and cost-sharing with recipients and employers. These demonstrations will test the cost impact of these new options, whether employers can be persuaded to participate, and their administrative feasibility.

State-Funded Medicaid Expansions

For many years, some states have used Medicaid program administrative mechanisms for state-only funded medical assistance programs. Usually in association with state general assistance programs, these states have offered entitlement to a range of medical services to indigent populations not eligible for Medicaid. Most of these programs limit benefits more narrowly than those available through the Medicaid program, sometimes covering just

[3]Maine has adopted all optional as well as mandatory Medicaid eligibility categories, so many children who would otherwise be eligible for the Maine Health Plan are enrolled in the Medicaid program.

outpatient services, or perhaps a limited number of hospital days. Among the states that have had state-only Medicaid programs for their general assistance populations are: Maryland, Massachusetts, Michigan, Missouri, New York, Oregon, and Pennsylvania (Desonia and King, 1985).

Historically, these state-funded programs, because they lack either federal matching dollars or private sector contributions, have been very vulnerable to cuts during economic recessions. There is some evidence that in the current 'down-turn of the economy, states with state-funded general assistance programs are once again being forced to curtail funding. Nevertheless, the last few years have seen in some states a new wave of state-funded Medicaid expansions which expand eligibility to categories of individuals whose income is above Medicaid's eligibility level and who may be employed or the dependent of an employed person. Some of these programs have added cost-sharing features, not characteristic of earlier state-funded Medicaid expansions, as they have expanded into higher income eligibility groups. Although these programs piggy-back on Medicaid provider reimbursement systems and eligibility determination process, they are frequently publicized and marketed under names that deliberately disassociate them from Medicaid, with its stigma of welfare participation. These programs are targeted to one of three populations: children, pregnant women, and/or the disabled.

Children's Programs

Several states have placed a priority on assuring the broad availability of preventive and primary care services to children. The earliest of these programs is the Minnesota **Children's Health Plan** (CHP), operational since July of 1988. This program is available to children in the state with household incomes up to 185 percent of the federal poverty level, who are not otherwise eligible for Medicaid. Although eligibility was initially limited to children up to the age of nine, the state expanded the program to children through the age of seventeen, in January, 1991. Families who appear to be potentially eligible for Medicaid are required to apply and be rejected before they are accepted into the Children's Health Plan. Those with private insurance that is less comprehensive than CHP may enroll. For those with dual coverage (currently about 30 percent of enrollees), the state employs a "pay and chase" policy with regard to coordination of benefits. The program covers non-inpatient services, including dental care, vision care, eyeglasses, emergency rwm care, outpatient surgery and lab tests, in addition to routine office care and immunizations. It does not cover mental health or institutional care services.

Families pay $25 per child per year as an enrollment fee up to a maximum of $100. There are no copayments or deductibles for services. Families receive care through any provider enrolled in the Minnesota Medicaid program, and these providers are reimbursed at Medicaid rates, through claims submitted to the Medicaid agency.

CHP has been coordinated with Minnesota's Services for Children with Handicaps (SCH) program, allowing children with dual eligibility to enroll in both programs through a single

application process. Dually eligible children get additional benefits through this double enrollment - services related to their handicap (including up to $15,000 for inpatient care) through SCH, and well-child and preventive services through CHP.

As of January 1991, the program had enrolled a cumulative total of 21,000 children, with an average daily census of about 13,500. The median income from employment for enrolled families in the second year of the program was $16,640 (around 133 percent of the federal poverty level). Ninety-five percent of the households have at least one working parent; in 46 percent of the homes, both parents are employed. The average cost to the state per enrolled child in 1990 was $180. Approximately $10 million was appropriated for this program for the 1990 - 1991 biennium.

Program satisfaction among participants seems to be high. The services most frequently received by enrolled children have been physician and dental services, prescription medications, and hospital outpatient services.

At least two other states are in the process of implementing Medicaid "buy-in" programs targeted to children. **Vermont** initiated a program in July of 1989, marketed as the **Dr. Dinosaur Program,** which extends eligibility to children under age seven to 225 percent of the poverty line and pregnant women with incomes to 200 percent of the poverty line. Those enrolled in the program pay no premiums and pay copayments on office visits of from $1 to $3, based on income. Services, reimbursement and administration are identical to those under the state Medicaid program.

Vermont has for many years permitted a short mail-in application for Medicaid, with no face-to-face interview required. Assets tests have now been waived for both Medicaid and the Dr. Dinosaur Program, making application very simple.

In the first year of the program, due to little publicity, enrollment was low. After some major marketing efforts, the program has expanded to 1,200 children and 38 pregnant women. An enrollment of 2,300 is targeted for July, 1991.

Colorado has authorized a similar program, scheduled to begin operations in 1991. Children below the age of nine, in households below 150 percent of poverty will be eligible. The program will cover non-hospital and non-institutional services. Colorado's program has developed a unique funding formula. $650,000 is to come from a "disproportionate share" adjustment to two hospitals in the state that receive public funds for charity care (University Hospital and Denver General). The legislative authorization calls for a match of at least 1: 1 by private donations in order for the program to become operational. Colorado is the only state to expand eligibility to children using, in part, private dollars, without first taking the Medicaid optional categories and obtaining the available federal match.

Pre-natal Care Programs

Many states, concerned about rising rates of low birth weight babies and stagnant rates of infant mortality, have focussed efforts on assuring early and appropriate prenatal care services. In the past few years, these efforts have been significantly bolstered by new options available through Medicaid, and some initially state-funded initiatives have been absorbed into the Medicaid program. As of July 1990, twenty-four states have adopted Medicaid eligibility for pregnant women above the mandatory 133 percent level. These higher eligibility levels range from 140 percent of poverty to 185 percent. In addition, forty-six states had dropped assets tests and twenty-eight adopted presumptive eligibility (NGA, 1990). A few states have expanded coverage of pregnant women even further, using state dollars. California, Massachusetts and Vermont are covering pregnant women to 200 percent of poverty, and Hawaii covers all uninsured to 300 percent (see description of Hawaii's SHIP Program, Chapter VIII).

In addition to more encompassing eligibility guidelines, Medicaid has expanded the range of service options for pregnant women. Case management, risk assessment, nutritional counseling, health education, psychosocial counseling, home visits and transportationare enhanced prenatal care services that have been adopted in part or in full, by thirty-six states (NGA, 1990). Again, in some instances, states have supplemented their own expanded programs with similar benefits. California, for example, has added home visits to its Comprehensive Perinatal Services Program.

An area where states have taken substantial initiative is in developing outreach programs. Many states are concerned that women who are currently eligible for Medicaid services are not enrolled in a timely fashion or do not seek out early prenatal care. Some of the new programs have placed a major focus on making information about program eligibility widely available, and encouraging early entry into prenatal care. Using multi-media campaigns including posters, brochures, television and radio, several states have launched mass educational efforts that emphasize the need for early prenatal care and the availability of coverage.

An early and successful prototype outreach effort is Utah's **Baby Your Baby** program. The Utah Department of Health received support from network television, Blue Cross and Blue Shield of Utah, the March of Dimes, and the Utah Medical Association Foundation to develop a media campaign that included television and radio spots, print advertising, posters and print support material. Women, once enrolled, receive an attractive and informative mother/child health record book which encourages them to record information related to their children's health and health care services and five newborn newsletters featuring developmental information tailored to the current age of each child, up to the first birthday,

The response to the program has been very positive, with applications climbing to close to 300 per month, in the first year of the program, following television and other media promotion. Although it is too early to fully evaluate the impact of the program on birth

outcomes, program administrators are pleased with what they believe is a trend toward earlier commencement of prenatal care.

Other states that have launched similar efforts under such names as "Healthy Beginnings" or "Healthy Baby" include Alabama, Alaska, Idaho, Colorado, Iowa, New Mexico and North Carolina.

Programs for the Disabled

Two states, **Wisconsin** and **Massachusetts,** have enacted programs that extend medical assistance eligibility to disabled persons who are ineligible for Medicaid, due to earnings or income. Both these programs provide coverage on a sliding fee scale, with no upper income limit, and both offer two options - a full, comprehensive plan for the uninsured disabled, and a supplemental package for those who already have comprehensive insurance. The supplemental package offers services frequently needed by the disabled and often excluded from insurance plans, such as long-term physical and occupational therapy, speech and hearing services, medical supplies and equipment, personal care services and (in the case of Massachusetts) alternatives to institutional care such as independent living center services, private duty nursing and home health aides. In both programs, services are obtained through Medicaid participating providers who are reimbursed at Medicaid rates.

The Wisconsin program is a pilot in Milwaukee County which runs from January 1990 until June 1991. Eligibility is limited to those over 18 years of age. The full coverage package is offered on a sliding scale with a minimum monthly premium of $8 and a maximum of $200. The supplemental package cost is a flat $75 per month.

The Massachusetts program, one of its **"CommonHealth"** initiatives enacted in 1988 as part of its universal coverage plan, offers coverage to both disabled adults and children. The premiums for both the comprehensive plan and the supplemental plan are on income-based sliding scales, ranging from no premium for those below 200 percent of poverty to 10 percent of adjusted annual income for those with adjusted incomes above $75,000.

The program had 2,500 individuals enrolled as of January, 1991; 1,600 adults and the balance, children. The program's appropriation for the current fiscal year is **$14,223,000.**

Summary and Conclusion

Over the past several years, states have significantly expanded Medicaid eligibility (often under the prodding of federal mandates) and enriched services for certain categories of the medically indigent, taking advantage of partially federally funded option for expanding access. Some states have built upon this foundation to expand services to new categories of the poor, usually with marginally higher incomes than federal standards allow. These Medicaid options and state buy-in programs offer a cost-effective, if traditional means of responding to the needs of the poorest of the uninsured. They are a particularly effective

way to target such vulnerable populations as children and pregnant women, or to make specialized services available to high needs groups, like the disabled. Although more expansive, the programs can suffer from many of the same limitations as traditional Medicaid: poor provider participation levels, categorical and rigid eligibility criteria and reinforcement of the public/private divide in the health delivery system.

The Medicaid demonstrations authorized by HCFA, however, are experimenting with fairly radical departures from Medicaid traditions. Whether by using private sector insurers and administrators, coordinating with work place benefits, or enrolling higher income persons at cost into the same plan as the Medicaid eligibles, these demonstrations are blurring the lines that separate public coverage programs from private. If successful, they may pave the way for new, more generalized flexibility within Medicaid and a new generation of public/private collaborations to meet the challenges of medical indigence.

Chapter III Developing The Health System Infrastructure and Targeted Service Options

Introduction

The policy debate regarding access to care, both at the national and state level, has been on funding mechanisms to expand access. This emphasis on methods to pay for care stems from the fact that both the public and private health care systems rely on insurance mechanisms and a largely private health delivery network. It is clear, however that in many circumstances, the access to care problem cannot be addressed through expanded entitlement or insurance coverage alone. Even with universal coverage, the need for publicly funded, direct service programs would probably not disappear. Moreover, if a policy consensus is reached regarding how best to finance health care, the question of what we expect to achieve from increased health care access remains.

The Department of Health and Human Services has recently issued Healthy People 2000: National Health Promotion and Disease Prevention Objectives which articulates a context for the policy debate regarding increased health care access. In it, the Department proposes a national agenda to achieve significant reductions in preventable death and disability, enhanced quality of life and fewer disparities in health status among populations within our society. It identifies a shared responsibility with states and others to carry out this national agenda.

The states have a critical role not just in experimenting with financing strategies to meet the needs of the uninsured, but in developing appropriate health care systems and creating direct services to meet special needs. States have been actively engaged in assessing problems of health care delivery, in developing policy to improve and enhance delivery systems and assuring that essential personnel, services and education are widely available. They recognize that increased financial access to health care will not diminish their responsibilities to eliminate non-financial barriers to care such as unavailability of providers, lack of transportation or insufficient services to meet the special needs of underserved populations.

Such concern for direct service and the health care infrastructure are not new and states have developed innovative programs to respond. Some of these programs address service integration and system development, some address personnel shortages and others address special populations or health problems.

Service Integration and System Development

To assure continued access, health care delivery systems must respond to demands created by changing demographics, new and emerging epidemics, economic downturns and other new mandates. Frequently, existing resources can be stretched by developing explicit linkage and coordination of services or by stimulating existing providers to refine or change their missions or priorities. Several examples of such state and local efforts exist.

Hospital Transitions to Respond to Changing Needs

Eighteen states have programs to assist hospitals obtain capital financing. Some place emphasis on special needs, such as Arkansas' Rural Health Services Revolving Fund or New York's Planning Assistance Grants for Rural Hospitals. Recent federal Medicare changes allow some hospitals to convert acute care beds to skilled nursing beds, or "swing beds", to respond to an aging population and reduced hospital census. Montana has experimented with converting frontier hospitals to medical assistance facilities which could provide temporary acute care only for 96 hours per admission. These initiatives address the reality of empty and struggling hospitals and the need, particularly in rural areas, to retain access to acute care.

Such conversions will be further stimulated by a new federal program, Essential Access to Community Hospitals (EACH), designed to help states develop more appropriate rural health care delivery networks.

Maternal and Child Health Services

In the last several years, Congress has expanded Medicaid coverage for pregnant women and children and made a number of changes to the Maternal and Child Health Block Grant legislation. Among these changes are the requirement that states must use at least 30 percent of the block grant funds for preventive and primary care for children and 30 percent for children with special needs. In addition, MCH agencies are now required, through an expanded application process, to include statewide needs assessment data in services to women and children and outline a plan to meet various national MCH goals. These changes are aimed at increasing access to services for this special population group and will stimulate increased coordination between Medicaid and MCH agencies. There are many examples of such coordination to improve access exist.

In **Alabama,** Medicaid and MCH jointly developed a freedom-of-choice waiver program that establishes county-wide systems for providing the full range of perinatal and newborn services. In each county, a "primary provider" under a contract with the Medicaid agency provides or arranges all maternity services for the county's Medicaid recipients. The designated "primary provider" receives a set fee for each Medicaid recipient, and reimburses other county providers (eg., participating physicians, midwives, health departments, hospitals and community health centers). Both agencies are better able to assure access to coordinated

an comprehensive MCH services in their joint effort to improve perinatal care and reduce infant mortality.

North Carolina's "Baby Love" program is the result of the combined efforts of Medicaid, Public Health, Rural Health and the Office of Health Resources Development. While all traditional providers participate in this program, primary providers are public, health departments and community/migrant health centers. Specific maternity care coordination requirements involve local health departments and other providers of care coordination with the service area.

In reviewing options for improving access to perinatal care, North Carolina Medicaid officials realized that implementation of an effective program required a statewide delivery system. The local public health and rural health clinics, in addition to the C/MCHs, provided the infrastructure for a statewide network of perinatal care coordinators and providers (Lewis-Idema, Falik, 1990).

Community-Level ***Service Integration and*** System ***Development***

The **Primary Care Health Care Consortium of Dade County** is a network of five federally funded community health centers, the Dade County Department of Public Health, two state and county primary care programs, and a hospital. The participating institutions serve over 200,000 patients in an urban area with high proportions of Cubans, Blacks and the elderly.

Organized as a 501 (c)(3) corporation, the consortium receives support for administrative purposes from the Dade County government. In addition to the federal funding available to the community health centers and through Medicaid payments, Dade County provides financial support for indigent care for the medically needy. This funding is channeled through a Public Health Trust which operates the hospital and one of the health centers.

The activities of the consortium have been focused on coordinating services between and among the centers and the hospital. Among the strategies the consortium has developed are: sharing specialty services among the centers; sharing equipment such as ultrasound; providing a mobile breast cancer screening unit; and providing services to the centers through the hospital such as bulk purchasing, billing and malpractice coverage. In addition, the consortium has developed a program of educational placement of students and residents to increase provider resources in the centers; and has developed a coordinated system of assignment of high risk pregnant women, to insure that neither the hospital nor any one center becomes over burdened (Lewis-Idema, et al., 1990).

Beaufort-Jasper Comprehensive Health Services (BJCHS) in South Carolina, is an example of a federally-funded community health center that has entered into a variety of jointly-funded ventures to provide comprehensive maternal and child health services. The center has contracts with state and local health departments to serve as the principal provider

in its locality of perinatal care, maternal and child health care, WIC, EPSDT and immunization services. In addition, BJCHS participates in a Perinatal Case Management Initiative, designed to provide case management services for pre and post natal care. This program includes: expedited Medicaid eligibility determination; needs assessment; and appropriate coordination of services, monitoring, follow-up and counseling. Because so many related services are provided through this one agency, it makes coordination and elimination of duplication particularly effective.

In addition, the center operates a special WIC incentive program funded through private corporation grants. This program rewards participation and compliance with "incentive gifts" such as a baby crib or layette and is associated with a measurable reduction in infant mortality over the last three years.

BJCHS is involved in a variety of other community health activities as well, including a primary care indigent care program, funded with local county funds, and a mobile care unit serving school aged youth, migrant labor camps, and local youth civic organizations (Lewis-Idema et al., 1990).

One of the most ambitious recent proposals regarding service integration and infrastructure development has emerged from the **Chicago and Cook County Health Care Summit.** This plan proposes to supplement the current $1.584 billion in federal, state, county and city funding of public health and indigent care, with limited new state funding and significant increases in Medicaid dollars (brought in through expansions in eligibility and aggressive outreach to enroll currently eligible indigent health system users).

But rather than focus on financing, the plan calls for a major reorganization of services to more prudently use existing resources, to significantly expand the availability of primary care, and to provide an accessible continuum of care to all residents of Cook County. The Summit proposes the formation of 14 "Corridors of Care" with formal networks of primary, inpatient and specialty public and private care providers. Explicit linkages among the providers will assure that patients entering anywhere in the system will be referred to the appropriate level of care. Ambulatory care, under this proposal, would be increased by the consolidation of limited service clinics into comprehensive health centers, the opening of a new health center on Chicago's West Side, increased provider staffing at ambulatory centers in high-need corridors, and the development of an agreement with the local medical society to encourage private physicians to donate 50 hours a year of free care.

The proposal encompasses major changes to the inpatient care system, as well. The Summit proposes to decentralize public hospital beds for general inpatient care through the purchase of existing facilities on Chicago's south side and west side, and through contracts with suburban hospitals to provide low-risk deliveries for uninsured women. The University of Illinois Hospital is proposed for tertiary level care, and a replacement facility for the current Cook County Hospital, encompassing 500 beds, would anchor the inpatient care system.

The Summit proposal recommends the creation of a number of governance bodies to oversee the development and coordination of services proposed. Each Corridor of Care would have a Board made up of providers, consumers and community representatives. In addition, the proposal recommends the creation of a nine member Cook County Health Council appointed by the Governor, the county Board President, and the Mayor of Chicago (CC and C Health Care Summit, 1990).

This Summit proposal was stimulated, like many others, by the increased pressure that the uninsured are placing on the health care system. However, it took as its starting point, not new insurance systems, but the crumbling health system infrastructure - from physical facilities to fragmented delivery systems - recognizing that the development of a solid delivery system and adequate provider base must precede new entitlements or coverage options.

Strategies to Reduce Provider Shortages

In many areas, particularly rural and minority communities, access to primary care is restricted due to provider shortages. Strategies to overcome this problem are almost all, of necessity, long-term; they encompass changes to the training and education of physicians to put greater emphasis on primary care, increasing training of allied health personnel, and trying to identify and assist providers willing to practice in underserved areas.

A number of innovative programs based on these ideas are operational which can serve as models for future program development.

Loan and scholarship programs

Nineteen states have developed programs to encourage rural primary care practice. Most will pay back or forgive student loans if physicians (and sometimes nurses) practice for a given period in rural underserved communities. A few states provide scholarships (rather than loans) conditioned on rural services. **South Dakota** and **Indiana** provide direct grants to encourage rural practice. **Tennessee** and **North Carolina** assist rural obstetricians to pay malpractice insurance premiums.

New York's Health Service Corps provides scholarships for nurses, occupational, physical and speech therapists, physician assistants, pharmacists, nurse practitioners and midwives in exchange for service within designated institutional and community based facilities such as state institutions, community health centers, and AIDS service sites. Since 1985, over 1,000 awards have been granted, and only five percent have withdrawn and three percent defaulted.

Other incentives for rural or underserved area practice

States can consider income tax credits to encourage health care providers to practice in

underserved areas. **Oregon** recently enacted such a credit for rural physicians, nurses, and physician assistants meeting prescribed criteria. States can also provide supplemental payments under Medicaid or other indigent care programs to reward rural practice, as **Kentucky** has done. Many states also provide recruitment and placement services to help communities seeking physicians to locate and attract them.

Community-Level Strategies to Reduce Provider Shortages

Paso Del Norte Area Health Education Program in El Paso, Texas, provides an example of a coordinated program between a university-based education program and two federally funded community health centers. The AHEC serves a 21,000 square mile region, both urban and rural, largely Hispanic and medically underserved. The linkage between the AHEC's educational programs and the health centers provides ambulatory primary care experiences for a full range of health professions students and residents, at the same time that it provides additional health care resources to this underserved area. In addition, the resources of the health centers are used to recruit and retain local Hispanic community residents for health careers. The program includes a family medicine undergraduate rotation and community health center preceptorships. In addition, the program provides the centers with dial-in access to the University Health Science Center's Library computer system.

In Bowling Green, Kentucky, South Central AHEC has developed linkages with the local health department, resulting in the development of several family practice rotations. One of these is a second year residency rotation in family medicine; one is a community-based training in occupational health, established in cooperation with the health department and the local General Motors assembly plant; and a third rotation, developed in cooperation with a nursing care facility and a hospice, provides training in gerontology,

These programs serve an area covering over **9,000** square miles, where at least 20 percent of the population lives below the federal poverty line (Lewis-Idema, et al, 1990).

With its mandated employer health insurance coverage of full-time workers, and subsidized coverage program for those who fall between the cracks, Hawaii has possibly done more than any other state to insure coverage of its citizens. However, state efforts to assure appropriate access are hindered by significant provider shortages, particularly among nurses and in the area of long term care.

Project Healthstart is an example of an innovative local effort to overcome health care manpower shortages. Developed by the Healthcare Association of Hawaii (HAH), the program recruits interested local high school juniors and provides a three week summer training program for basic health care jobs. The students get school credit for the program, and those that complete the course and their high school education are offered jobs in member facilities upon graduation. Follow-up training in computer and medical record skills is also available.

This program is the first initiative of the Hawaii Center for Healthcare Occupations, set up by HAH. The center also plans major recruitment efforts in many health professional areas, particularly nursing, and is providing funding for additional nursing and public health education programs at the University of Hawaii and community colleges (Friedman, 1989).

Community Scholarship Programs

Last year, Congress enacted a measure (P.L. 101-527) that will provide federal matching funds to communities that sponsor local residents for health professions training in primary care. Inspired by the account of a rural underserved community that raised money to send a local physician's assistant to medical school on the condition that he return and practice in the community, legislation was proposed to encourage and provide financial support to other such efforts. These demonstration grants specify that the federal funds will provide 40 percent of the scholarship, the state will provide between 15 percent and 25 percent, and the local community will provide not less than 35 percent and not more than 45 percent. Recipients must agree to return to the community for a period equal to the number of years of scholarship-funded training, or two years, whichever is more. $500,000 in federal funds are being made available through a competitive grant process for fiscal 199 1.

This program builds on the concept that capacity building in underserved areas is much more successful when local talent is used than through transplantation from other areas.

Direct Service Programs and Special Populations

A number of states and local communities are responding to the needs of special populations and underserved communities with direct service programs. These efforts fall into two categories. Most of the states that have enacted comprehensive, multi-faceted programs to tackle the problem of the uninsured have included enhanced funding of publicly supported primary care among their measures. In other instances, states or localities have responded to the pressing needs of particularly high risk populations or communities, whether drug addicted newborns or persons with AIDS. Many of these programs received varying amounts of Federal subsidies.

Enhanced Priiary Care and Preventive Services for Underserved Populations

Connecticut included in their broad based act to enhance access, funding for a "direct services program. " This measure will award three year grants to primary care providers and community health centers who can provide or arrange for primary and preventive services; and who can refer and make arrangements for specialty services. Recipients of the grants must serve the uninsured on a sliding fee scale. The grants can be used for operating expenses, physician recruitment or capital expenditures.

In **Hawaii,** where almost everyone is insured, either through their employer or through the state's SHIP program for the low-income uninsured, the legislature has set aside

$400,000 in SHIP funds for use by clinics to enroll and provide services to those who are unlikely to ever use an insurance card.

With language very similar to Connecticut's, **Maine** included funding for primary and preventive services, to be awarded through a competitive grant process, in its comprehensive package of expanded access measures.

Direct Funding for Programs Targeted to Special Populations

As noted earlier, there are a variety of health problems that call for concentrated, multi-disciplinary approaches for effective treatment. One of the most pressing problems faced by the health system today, is the epidemic of addictive drug use and its effects both on the users and babies born to addicts. A number of creative programs have been developed to attack these problems from a public health perspective.

The Healthy Infant Program at Highland Hospital in Oakland, California is targeted to women who deliver drug exposed babies. Following delivery, these women are offered enrollment in a program that lasts a minimum of one year, and, sometimes two. The alternative to enrollment is a referral to Child Protective Services. They are enrolled with neighborhood health centers or the hospital's clinics for medical care,and are assisted with enrollment to other available programs, such as WIC, AFDC, and Medicaid, and are assisted with finding adequate housing, if necessary. Each client receives a home visit, a psychosocial assessment, and an assessment of support systems at home. For those who can return home with their babies, the hospital provides parent support groups, grandparent support groups, and cocaine anonymous groups, that meet once a week. Program staff maintain at least monthly contact with enrolled clients and are often involved much more frequently. This program receives 75 percent of its funding through the state Medicaid EPSDT program, and is the first program of its kind to use EPSDT funds in this manner. This funding is supplemented with private corporation grant funding and State MCH funds. These grants have allowed the program to expand to include family planning services for the mothers, and parenting classes (separate from the parent support groups) (Thompson, 1990).

The U.S. Office of Substance Abuse last year gave $31 million to private groups and hospitals in 31 states to fund similar programs for drug addicted boarder babies. In **Washington D.C.** a therapeutic day nursery for babies has been developed to complement an eighteen month program of detoxification treatment, job training and training in child-rearing skills for the mothers. The **Catch the Hope Program** in Roxbury, **Massachusetts** provides treatment in a halfway house for drug-addicted pregnant women from the state prison. The program allows the women to keep their babies, rather than give them up to foster care, and provides medical treatment, counseling, and child care classes (Cooper, 1990).

Summary and Conclusion

The goal of increasing access to health care is to assure a fuller measure of health and improved quality of life for all citizens. To reach that goal requires both financing and an effective and reliable health care delivery system. Gaps in the health delivery system as well as high risk populations call for interventions that go beyond entitlement or insurance coverage. Programs to serve the medically underserved and high needs groups can call for an intensive, if focussed, allocation of resources. However, as shown by programs in areas as diverse as Montana, El Paso, and Chicago, substantial gains can be realized from careful coordination and maximization of existing resources. Particularly in the area of maternal and child health, multiple funding and programmatic resources can be brought together through Medicaid, WIC, MCH funds and state or local public health resources to offer enriched health care services to high needs populations. In addition, traditional resources such as EPSDT and institutions such as hospitals, can be used in creative ways to meet the needs of special populations.

Chapter IV Public Incentives for Purchasing Private Insurance

Introduction

As described in Chapter I, over three-quarters of the 31 million uninsured Americans are workers (about 60 percent of whom work full-time) or their dependents. In view of this work place connection, state and federal policy makers have considered expanding work place insurance opportunities as a means to finance health care for a large number of the uninsured and medically indigent population. This approach builds upon the existing tradition of obtaining insurance through the work place, reinforces the incentive to work, and distributes the cost of insurance among employers, employees, and the government.

The opportunity that work place insurance programs offer to share the cost of expanded coverage makes such strategies particularly attractive. The cost of purely publicly-funded health care programs in an era of tight budgets has led many states to look for ways to develop "public-private partnerships" that might include incentives for employers to offer insurance or for workers to buy coverage available in the work place but unaffordable.

About half the nation's uninsured adults work in larger firms. But because the risk of being uninsured is greater for workers in small firms, these strategies have focused almost exclusively on small business (Bartlett and Carroll, 1990).[1] In national and state-specific surveys, smaller firms cite cost as their primary reason for not offering insurance. Thus, these projects generally attempt to lower insurance premiums to the employer and/or employee. They have also helped the insurance industry understand and reach small employers and develop new products that can meet the needs of that market. Incentives used by states to encourage increased work place insurance include direct and indirect premium subsidies, assistance in developing and marketing new insurance products, income tax credits, and "pay or play" payroll taxes plus credits. Although still in early stages, these experiments are revealing important information regarding the use of private insurance and its limitations. The subsidy strategies are discussed below. Strategies based on tax incentives are discussed in Chapter V.

All of the incentive options rely on voluntary participation by employers and employees. The most direct way states could increase work place insurance (if they could overcome political opposition), would be to enact statutes requiring all employers to offer it to their employees. However, as described in Chapter V, the 1974 federal pension reform law,

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[1] See discussion, page 37, of Wisconsin's incentive program for a description of a program targeting uninsured workers in insuring firms. Their experience suggests that finding those firms and convincing their employees to apply for state assistance may be even more difficult than marketing to currently uninsuring small firms.

ERISA (Employees' Retirement Income Security Act) has been interpreted to prohibit direct mandates.

While sharing insurance costs is attractive, the price of reaching uninsuring employers and convincing them to buy coverage limits the voluntary strategies. Work place programs also typically neglect part-time workers and the unemployed. Further, close to half of uninsured workers and their dependents are employed by large firms, many with benefits plans in place. Thus, other states are experimenting with incentives for individuals to buy lower cost insurance regardless of their work place connection. These individual coverage programs are also discussed below.

Incentives to Increase Employer-Based Coverage

Direct Premium Subsidies

Over a dozen states, many under grants from the Robert Wood Johnson Foundation, are subsidizing the cost of health insurance premiums for lower income workers, paying part of the individual or family premium on an income-based sliding scale (generally up to 200 percent of the federal poverty level) (Appendix I, Table A). Most subsidies limit individual or family premium contributions to around three percent of family income, and some states increase subsidies to the lowest income population or to families. Most of these projects are limited to a few test sites within a state, and most contract with a single insurer, usually an HMO, to offer insurance at each location. More detailed descriptions of each of the projects noted below can be found in Appendix II.

Small Employer Group Insumnce Subsidies

Most of these projects assist small firms and their employees to buy health insurance. In order to target subsidies to encourage new coverage and to minimize direct competition with private insurers, the public projects subsidize only firms that have been without insurance for a given period of time, usually 6 to 18 months. This approach focuses public funds on the currently uninsured and limits switching from richer to leaner plans. It also eliminates insurers' argument that government is directly competing with industry. However, a policy limiting subsidies to previously uninsured firms may miss many small firms that drop coverage due to price or other insurance practices (Ohio Department of Health, 1990). About 40 percent of the firms enrolled in Denver's SCOPE project, for instance (which has no public subsidy and does not limit enrollment to uninsured firms) were insured when they applied for SCOPE but reported they were about to drop coverage primarily because of its cost.

Michigan's program subsidized premiums in firms without insurance for at least 2 years. Employers must pay 1/3 the premium; the state pays the other 2/3 for workers and families with income under the poverty level or 1/3 of the premium for employees

between one and two times poverty.[2]

Maine uses a similar income-based scale in its two demonstration sites to support firms with under 16 full-time employees but not offering insurance for at least 12 months. Employers joining the managed care plan must pay half the premiums; the state pays the other half for workers under the poverty level and a declining share as income rises, up to 200 percent of the poverty level.

Florida's program subsidizes insurance for firms under 20 employees not offering insurance within the previous 6 months. Rather than an income-based subsidy, the state pays its HMO partner directly in order to lower the premium for family coverage. Since its subsidy is available to all employees, regardless of income, it avoids the cost of determining income eligibility.

New York has several health insurance pilots, two of which subsidize half the cost of employer-group insurance in firms under 20 employees uninsured since January 1988. Employers pay the remaining half; employees (regardless of income) pay nothing.

Ohio has two pilot projects subsidizing low wage workers in firms without insurance at least 18 months. In the HMO pilot the employer pays $49 per employee or $100 per family and the state subsidizes low income workers' premium share. In the PPO pilot, the employer pays a negotiated portion (under half) of the premium, and the state and employees split the remainder.

Massachusetts has four pilots to subsidize employer group insurance for firms with under 25 employees and uninsured at least one year. The public subsidy varies from 5 percent to 14 percent of the premium.

Wisconsin has recently completed two employer group insurance demonstration programs. In the "non-insuring firm pilot," the state subsidized employers of under 20 workers that did not offer insurance within the previous year and that enrolled in a choice of state-approved plans. The state paid up to 75 percent of the premium on a sliding-scale basis for enrollees with incomes under 175 percent of the poverty level. Employers were not required to contribute to premiums. In the "insuring firm pilot," the state subsidized insurance for employees in larger firms (100 or more workers) who had not purchased insurance offered in the work place for at least 6 months.

[2]This program was originally designed for firms that employed former welfare recipients. So few of these new employees were located, however, that the program was opened to all uninsuring, low wage employers.

Direct Employee Premium Subsidy Program Experience

The experiments in subsidizing health care for uninsured workers provide important information about the health insurance market and the behavior of insurers, employers, and consumers. Despite the hope that employer incentives would significantly decrease the number of uninsured workers and family members, it is not clear what impact a purely voluntary approach will have. Among the preliminary findings from this variety of demonstrations are the following:

Very small groups are enrolling. The employer insurance demonstrations are tending to enroll very small groups (one to five employees). It is true that the smallest firms are least likely to be insured: only 37 percent of firms with under five workers offered insurance in 1989 compared to about 66 percent of all small firms responding to a NFIB survey (Hall and Kudor, 1990). Many of these very small firms have clearly been locked out of the market due to the lack of affordable insurance plans for small businesses. However, the projects have been less successful in enrolling uninsured firms of between five and twenty workers, despite the subsidies. Barriers other than price may be significant deterrents among firms of this size which have chosen not to provide benefits. But enrollment experience may suggest that while price is important, small firms are attracted to HMO and other managed care plans made available under the projects.

Marketing is costly and time-consuming. As insurers have always known, reaching and enrolling small employer groups is very costly. The projects have spent up to $150 per enrollee on marketing costs. Small employers make deliberate choices, based on financial realities as well as personal and employee circumstances. They do not act quickly, and they require considerable information and marketing assistance before making a decision, The New York regional pilots found that direct mail campaigns were insufficient and telemarketing of limited use, while direct outreach activities through business, civic, and community organizations seem to be the most effective, albeit costly, marketing strategy. Targeting uninsured firms can also be inefficient when it identifies businesses that don't offer coverage because most employees are covered as dependents through other employers' policies.

Premiums must be reduced substantially from market rates. Plans whose net effective premium[3] is reduced 25 to 50 percent below market rates for similar benefits (by the combination of direct and indirect subsidies, managed care strategies, and provider discounts) have had the greatest enrollment success.

Even with significant premium discounts. enrollment is modest. Early experience suggests that only between 3 percent and 10 percent of the target population (uninsured workers and dependents associated with small firms) is likely to be enrolled after about

[3] That is, the total amount of premium the employer pays for subsidized and non-subsidized employees.

two years of marketing (See Table 5). Surveys show that 25 percent to 35 percent of small employers are unwilling to participate in any voluntary insurance program, often because they do not believe that health care financing is an employer's responsibility (Hall and Kudor, 1990). A large majority of firms are interested in insuring their workers but many apparently feel unable to afford even the subsidized products.

Employer approaches do not reach part-time workers. Due to both insurer and employer practices and unaffordable premiums, employment-based insurance strategies cannot reach most part-time or seasonal/part-year workers, who represent about 16 percent of uninsured workers.

Employers are concerned with small group market inequities. While price is the major obstacle to employers offering insurance, small uninsured firms fear the volatility of the current insurance market, where average premiums have recently increased from 10 percent to 40 percent per year, firms with significant claims experience have seen increases as great as 400 percent, and enrollees face new exclusion periods when the employer changes carriers. (Reform of the small group insurance market is explored in Chapter VI.)

Early utilization experience is good. Preliminary evidence may discredit the myth that small groups are less healthy. Early utilization experience in the demonstrations has been similar to or better than that of larger insured groups. Thus, although adverse selection may occur due to the voluntary nature of the small group insurance purchase, it appears that low premiums can attract an average distribution of healthy and sick enrollees and permit a broader spread of risk similar to large groups.

A single plan may be easiest to market. Although employers express a preference for choice among insurance plans, the most successful subsidy projects seem to be those that have negotiated a small group product with a single carrier (HMO or indemnity plan) and can thereby avoid the employer's costly search process. Apparently the time required for small employees to shop for and choose a plan is a more important consideration than availability of choice. Projects with a single plan have sales staff or trained brokers to help employees understand the plan and process paperwork.

Insurers have not been eager to participate in subsidy projects. Many of the small group insurance subsidy projects have negotiated a partnership with a single insurer in each location, generally a regional HMO. Although willing to talk with all carriers, the projects found limited interest among traditional indemnity plans, apparently due to uncertainty about the small group market and concern that public subsidies may be short-lived. There has been some development of low cost plans, due to both imitation of successful models and insurance mandate waivers (discussed in Chapter VII), so perhaps the positive employer reception and initial cost experience have reassured the industry.

Table 5

*Selected **Insurance** Project **Enrollment** Rates and Projections*

Project	Date Begun	Enrollment Rate	Projected 24 Month Period	Penetration Rate[1]	Premiums' % of Comparable Benefits
Denver[2] (SCOPE)	9/89	280 per month	6754	2.8%	40%
Florida (SBHAC)	5/89	201 per month	4818	3.4%	70%
MaineCare	12/88	*38* per month	930	9.3%	*68%*
Michigan	5/88	37 per month	883'	1.6%	84%
Washington (BHP)	1/89	614 per month	14,727	n.a.[4]	80%

'Target population estimate calculated from number of uninsured businesses, an assumed average small business size of 6 (from Maine small employer survey and an assumed family size of 2.4 (from Washington survey).

[2]**Enrollment** figures reflect only previously uninsured groups (about ⅔ of all groups), though insured groups may enroll.

[3]**Michigan** actually enrolled 1,026 in 28 months.

[4]**Target** population not available for Washington pilot sites.

Medicaid "Buy-Out" of Private Insurance

Another approach that states can use to subsidize insurance is to buy private insurance in lieu of Medicaid for Medicaid-eligible families who have access to but cannot afford employer group insurance. Section 4402 of OBRA 1990 requires states to pay premiums and cost sharing for group health insurance for persons eligible for Medicaid when it would be cost-effective, as defined under HCFA regulations.[4] States must require that such persons enroll in the group plan or forfeit Medicaid entitlement, although failure of a parent to do so would not disqualify a child from Medicaid coverage. States may permit enrollees to remain in group insurance for 6 months, even if they lose Medicaid eligibility. Premiums for all enrollees and cost sharing for Medicaid-eligible enrollees are medical assistance expenditures that qualify for Federal Financial Participation.

This new Medicaid requirement was foreshadowed by programs in several states. For instance, for several years New **York** has been evaluating insurance available to Medicaid applicants in order to buy insurance when it is cost effective. In 1987 the state developed a computer software program that estimates each applicant's predicted medical expenses based on age, sex, geographic area and aid category and compares expected medical use with services covered in the group insurance policy. County eligibility workers evaluate each policy based on the automated system and their own judgment. The state has enrolled 25,000 cases (between 50,000 and 75,000 people) in employer insurance or conversion plans (Buzzard, 1990). Since medical care payments are made by insurance companies, state officials do not know the precise impact of using third party coverage, but they estimate savings of $200 to $300 per person. A similar program is operational in **Minnesota.**

A 1990 **Connecticut** statute and a program recently begun in **Maine** (as discussed in Chapter II) permit the states to pay premiums and cost sharing for children or adults eligible for group coverage, when such enrollment would be cost effective. Unlike New York, Maine does not evaluate predicted medical expenses of each enrollee, but merely compares benefits and the employee's premium share to average expected costs under the public program. In its first four months of operation, Maine has determined that it is cost effective to buy group insurance for about 205 of the 9,700 enrolled individuals, though the process of evaluating insurance policies is cumbersome.

While it is conceptually appealing to coordinate Medicaid and work place insurance, for instance, to reinforce the value of work for low income people, the new Medicaid mandate may be complex to administer. Assuming HCFA establishes appropriate standards for cost-effectiveness, states will need first to identify other coverage, obtain accurate coverage

[4] Cost effectiveness is supposed to assure that overall Medicaid payments will be lower by buying families into group coverage. It must, for instance, take into consideration the costs of enrolling people not eligible for Medicaid, such as parents, in order to obtain family coverage for children. The law is effective January 1, 1991 (or later if state legislation is necessary), regardless of whether federal regulations have been promulgated (See Conference Report on OBRA 1990, P.L. 101-508).

descriptions, and then evaluate each policy under the cost-effectiveness tests. States must determine whether to work through the employer who buys the group insurance, directly with the insurer (as in Maine), or with the enrollee (as in New York). As discussed in Chapter II, Maine's experience in beginning such a program can be instructive.

Another provision of OBRA-1990 (Section 4713) permits state Title XIX programs to purchase "continuation" coverage[5] for people eligible under COBRA with incomes under the poverty level and assets up to twice the SSI level but only if the employers have at least 75 employees. Thus, states can purchase group insurance for many formerly employed persons with AIDS who become eligible for Medicaid. As with the employer group insurance mandate, states will want to evaluate policies for cost-effectiveness. The opportunity to share the predictably high cost of AIDS care with employers will make this option very attractive to states with large Medicaid AIDS caseloads.

Indirect Premium Subsidies

Explicit premium subsidies targeted to low income workers require states to determine eligibility, a time-consuming and costly process. To avoid this administrative complexity, several states provide other types of subsidies as part of their arrangements with insurance partners. In some instances, states centralize some administrative or marketing functions within a state agency. Limiting insurer risk is another indirect subsidy that not only has the direct result of lowering premiums but also can make insurers more comfortable in entering the unfamiliar territory of the small group market.

Arizona, Florida, Maine and Massachusetts have agreed to buy a reinsurance policy for the insurance partner or otherwise to cap the insurer's exposure for high cost cases. These agreements not only bring down costs, but also allow states to experiment with new and more liberal medical screening and underwriting criteria. Massachusetts, for example, does not allow exclusion of individuals from its pilots based on medical conditions. However, there is a 10 percent cap on the number of uninsurable persons allowed in the plan, with a waiting list, if necessary, for additional applicants (HIAA, 1990).

In **Arizona, Florida, Maine, and Washington** a state agency processes eligibility for the project, though in New York and Massachusetts, insurers perform this function. Only Arizona uses its Medicaid agency (AHCCCS). The other states established separate agencies to avoid both a Medicaid stigma and new burdens on Medicaid eligibility staff.

In Arizona and Florida the state sends bills and collects premiums.

[5] 1985 COBRA, P.L. 99-272, required employers of 20 or more people to offer the opportunity for discharged employees to continue their group coverage at the group premium for 18 months (plus 11 more months at 150 percent of the premium for people disabled when they left employment).

In most of the Johnson Foundation pilot projects the states have assisted in the costs of new product development and provider network recruitment, substantially subsidized insurer marketing costs, and devised new strategies to reach the small group insurance market. Grants or contracts for designing innovative insurance products (as done in Massachusetts) could be an important, limited role for states to encourage more private sector health insurance initiatives.

Other non-subsidy cost reduction techniques include deep provider discounts and the active use of managed care plans such as PPOs and HMOs, as the insurance partner for most of the demonstration programs.

Individual Insurance Subsidies

Some states have chosen to forego the opportunity to share premium costs with employers and instead are offering individuals the chance to buy subsidized individual insurance policies. Individual insurance subsidies fall into two categories: directly subsidized health insurance, usually in an HMO, for families meeting specified eligibility criteria, and subsidized risk pools that offer coverage at artificially capped rates to individuals with high risk medical problems.

Washington's Basic Health Plan offers enrollment in nine HMOs in seven sites to individuals and families with incomes under 200 percent of poverty level. Unlike most other entitlement or subsidy programs, the BHP requires some cost sharing by those below poverty (individuals below 75 percent of poverty, for example, pay $7.50 per month) and, nevertheless, appears to have substantial participation rates by the very low income groups. State subsidies decrease as income rises but average about 80 percent of the premium.

Ohio has one health insurance pilot to cover families with incomes under 300 percent of the poverty level who leave AFDC for a job that does not offer insurance. The state's income-based subsidy pays, on average, 93 percent of the family premium in an HMO.

Three of New **York's** health insurance pilots subsidize HMO or other managed care insurance plan premiums for individuals with incomes up to 200 percent of the federal poverty level. Individual premiums may not exceed 2 percent to 4 percent of gross family income; the state's subsidy will be 62 percent to 91 percent of premiums.

New York's Child Health Plan will permit children throughout the state to enroll in insurance (Blue Cross or several HMOs) for an annual fee of $25 per child for children in families with incomes over 133 percent of poverty (it is free for children not eligible for Medicaid in lower income families).

Massachusetts has one pilot program to subsidize premiums for individuals uninsured at least one year with incomes under 300 percent of the poverty level.

Connecticut enacted legislation authorizing development of subsidized private insurance coverage for children in families with incomes under 200 percent of poverty and pregnant women with incomes under 250 percent of poverty. Insurance products and subsidy scales are under development.

Other than Washington's Basic Health Plan, the individual insurance subsidy programs are newer than the employer group projects and not easily evaluated. There is also less information about the target populations in those states from which to estimate penetration. Washington's large enrollment is likely to be due to its high subsidy. Its experience also suggests that it may be easier to market a subsidized coverage plan directly to individuals than through employers. While work place insurance strategies have the advantages of sharing health insurance costs with employers and reinforcing the connection between employment and insurance, they require overcoming two significant marketing hurdles: the employer and the employee.

High Risk Insurance Pools

Another type of individual subsidized insurance is represented by the "high risk" or "uninsurable" pools now extant in about half the states (Appendix I, Table A).[6] Subsidies come from both public (general revenue) and private (insurer assessments) sources. These pools generally offer health insurance to individuals and dependents who have been rejected by one or more health insurers due to the existence of medical conditions (such as AIDS, heart disease, diabetes, cancer, or stroke) and are therefore denied health insurance at any price. In most pools, applicants with specific high risk diagnoses, such as AIDS, may enroll without first applying to a private insurer.

If part of a large employee group, people with such medical needs can usually be covered, but if they seek individual or small group insurance, the condition, the individual, or sometimes the entire group is denied coverage. A very rough estimate is that about one-half to one percent of the U.S. population is uninsurable (Wilensky 1986). As insurance carriers increasingly compete by avoiding questionable risks, more people may be labeled in this category.

These risk pools offer traditional "major medical" (hospital and physician) policies with deductibles of $150 to $1,000, coinsurance of 20 percent, and an out-of-pocket cap of $1,000 to $5,000 per year. Premiums are limited by statute and can range from 125 percent to 400 percent of the cost of individual coverage for a standard risk (healthy) subscriber of the same age and sex. Since actual premiums average about 150 percent of a standard individual premium, these plans are unaffordable to low or moderate income families in states other than Maine and Wisconsin, which subsidize premiums for low income enrollees. Although

[6] The U.S. General Accounting Office reported that in 1987 Blue Cross plans in eleven states still permitted enrollment of individuals without regard to medical condition. These plans thus serve as high risk pools in those states.

the pool plans accept people regardless of medical need, they generally attempt to encourage early enrollment and control costs by excluding pre-existing conditions from treatment for three to twelve months. Plans that have waived pre-existing condition exclusions have experienced sharp increases in claims (U.S. GAO, 1988).

Despite the high premiums, because of the greater medical needs of their subscribers and limited use of managed care strategies, the pools lose money. The loss ratio in six plans averaged 1:60 in 1986 (i.e., they cost 60 percent more than premium income) (U.S. GAO, 1988). The costs that exceed premium revenues are generally spread among all indemnity insurers and HMOs doing business in the state. In most states these assessments can be credited against premium taxes (a general fund tax expenditure). Since ERISA has been interpreted to prohibit states from collecting such assessments from self-insured employers, this financing mechanism may contribute to the trend to self-insure, eroding the base over which to spread pool costs. In a few states, pool costs are financed through general fund appropriations (Illinois), an individual income tax surcharge (Colorado), or a hospital revenue tax (Maine).

Experience With Incentive Approaches to Date

Based on preliminary experience of these projects, we can draw tentative conclusions about these incentive approaches:

Individual subsidies are more costly but may be easier to administer than employment-based subsidies. While working through the employer permits sharing premiums, this strategy involves an additional layer of decision-making: the employer must first decide to offer and contribute to the plan and then the employee must choose to share in its premium. Individual subsidies are more costly (Washington pays about 80 percent of the premium for its individual enrollment plan, compared to Maine's payment of 40 percent for an employer-based plan). But it may be more efficient and effective to subsidize individual enrollment for low income populations. On the other hand, individual subsidies may discourage small or low wage employers from continuing or considering to insure their employees. Administrators of the individual subsidy programs express concern that people will leave employer-sponsored insurance for public programs; and Washington plans to study this issue over the next year.

Voluntary and emulover-based insurance approaches are limited in their effect. As Table 5 illustrates, voluntary approaches appear likely to insure only a fraction of the target population. Employer-based approaches cannot address the part-time workers or those out of the labor market.

Market reform may be necessary to keep small groups in the insurance market. Price reductions are a necessary but insufficient means to encourage employers to enter and remain in the insurance market. Industry screening and rating practices pose additional barriers (see Chapter VI).

Broad-scale subsidies are costly. Subsidies for individual insurance targeted to a poor and near-poor population represent at least 80 percent of the average premium, often much more. To expand the Washington Basic Health Plan to the more than 400,000 lower income uninsured in the state would cost over $30 million, far beyond the state's current fiscal capacity. Even the lower subsidies for the most successful employer group insurance plans (about 30 to 40 percent of the premium) are too great for states to expand their coverage to the full 60 to 70 percent of the uninsured who are attached to the workforce.

The unpredictable nature of public subsidies may impede Dub&-D&ate partnerships. Projects designed as public partnerships with employers and insurers require trust and active private sector participation. While indirect subsidies, such as marketing and product development cost, can be short-term, most direct premium subsidies require a long-term public commitment. Though some small firms will prosper and become more able to pay for a greater share of insurance over time, most low income workers are likely to need permanent subsidies. Several of the demonstration projects have been so well received that they are funded past their initial projections (though they are usually not expanding to new enrollees), but some of the public subsidies are ending (Demkovich, 1990). It will be important to observe employer reaction to project termination. When Michigan reduced employer subsidies from 33 percent to 25 percent in 1990, no firms dropped coverage but the limited nature of pilot projects may temper enthusiastic involvement of needed private sector partners (Ohio Department of Health, 1990).

High risk pools Drovide coverage for only a small part of the uninsured population. They have enrolled less than 10 percent of the estimated uninsurable populations in the six states where they have operated for eight to ten years. Pools are certainly a limited response to the broader need for affordable health insurance. They can, however, assist middle or upper income people who can afford to buy this subsidized insurance. And they can help small firms (that may be disqualified from coverage due to the medical condition of a single employee) to purchase insurance for healthier employees by moving those with medical conditions into the pool.

The interface between high risk pools and small group insurance is not well developed. Some of the small firm insurance incentive programs are attempting to use the high risk pool as a risk-sharing arrangement with the HMO insurance partner. But, beyond such concerted referral efforts, it is difficult to make insurers, brokers, and employers aware of the potential use of the risk pools to permit the firm to insure other employees through regular group insurance. Insurance agents and brokers (through whom most small firms buy insurance) often are unaware of risk pools that could make insurance for small groups more available or affordable. Public education would help improve the use of pools, and insurers rejecting individual or group applicants due to medical conditions could be required to inform them of the existence of the pool, as is done in Wisconsin. The employer and employee will still face the issue of the difference

in coverage between most pools and traditional group insurance and the question of who will pay the higher risk pool premiums. Further, the explicit "dumping" of high risk individuals who have group plans available to them into high risk pools is at best a controversial strategy. While this practice may make coverage affordable to a small group which would otherwise face exorbitant costs, it encourages risk avoidance practices in the small group insurance market that are coming under increasing regulatory scrutiny (see Chapter VI). Proposals that would broadly spread the cost of high risk individuals through reinsurance may be a better option (see discussion of HIAA and NAIC risk distribution proposals, Chapter VI).

Chapter V Tax Incentives

A state's taxing power can be used in varying degrees to provide stronger or weaker incentives for individuals and employers to buy health insurance. Such tax strategies raise federal ERISA issues, discussed below, that are not yet resolved by the courts.

Voluntary Income Tax Credits

Federal Low Income Family Health Insurance Tax Credit

In OBRA 1990 Congress enacted a federal income tax credit for tax years 1991 and beyond for families with earned incomes up to $21,000 (adjusted annually by the CPI) who enroll their dependent children under age 19 in health insurance. The credit is available for the cost of the plan up to a cap and varies by family income level but not by the number of children enrolled. For families with incomes of about $11,000 in 1991 (approximately the poverty level for a family of three), the credit is projected to be $426; it declines for higher income families and is phased out at income of about $21,000.

The credit is only available for after-tax insurance premiums, that is, not for an employer-sponsored pre-tax insurance or cafeteria plan. It would also cover individual plans, such as those under development in New York and Connecticut. Because the statute speaks in terms of "insurance," it is not clear whether public programs without an insurance underwriter (such as Minnesota's or Colorado's Child Health Plan) will qualify for the credit.

The effect of the credit will be to reduce the total price that low income families must pay for children's health insurance. However, even assuming that eligible families are aware of the credit and understand how it may benefit them, the credit may serve more as a reward for buying insurance than as an incentive to do so. Although the credit is refundable (families with no taxable income can receive a payment up to the limit of the credit), families must still have cash available for monthly premiums. Unless families adjust their withholding to increase their take-home pay, the credit may not serve to lower initial premium prices and thus may not significantly improve access to insurance.

State Employer Income Tax Credits

Several states **(California, Kansas, Kentucky, Massachusetts, Oklahoma,** and **Oregon)** have enacted tax credits for small employers (under 25 to 50 employees) buying insurance for employees (Appendix I, Table B). The credits range from $15 to $25 per month (20 percent to 50 percent of the premium) and are generally available primarily to small firms not offering insurance for between 12 and 36 months. The laws require employers to contribute a specified percentage (25 percent to 75 percent) of the employee premium. Most

of the credits require actual taxable income, although Oklahoma's is refundable. The credits are short-term, lasting from two to five years and declining in some states over that period.

Although the credits in **Massachusetts** and **Oregon** have been in existence for one year and two years, respectively, there are no data on the number of firms that have claimed or plan to claim the credit. Oregon's credit is available only to firms that buy insurance through a state pool offering several low cost insurance plans. While 1,730 firms participated in the state pool as of November **30,** 1990, the state's tax form does not permit the state to identify which firms have taken the credit.' Massachusetts, where the credit can be claimed in 1991 for tax year 1990, will be examining its tax credit experience later this year. The state's small firm pilot projects use the existence of the tax credit in marketing, but state program administrators do not believe that by itself the credit is a significant incentive for employers to start buying insurance.

The credits are available only to non-insuring firms on the theory that they are designed to encourage offering initial insurance.[2] Yet like the individual federal tax credit described above, such business tax credits (even when refundable) do not directly reduce premiums, which require monthly cash flow. Even when they represent a large fraction of the premium, they are most likely to serve as a reward for employer conduct or an economic development stipend rather than as a significant incentive to offer insurance.

States that require employers to participate in a pool or buy from a set of state-approved plans have the advantage of assuring that the insurance is adequate to justify a public subsidy. On the other hand, requiring state approval involves establishing standards and administrative costs. And requiring employers to join a pool or buy from a limited number of plans may discourage employer insurance purchase. Furthermore, conditioning the credit on plan design may raise ERISA problems, described below.

"Pay or Play" Taxes

The Model

Recognizing both that ERISA forbids an explicit employer insurance mandate and the limitations in relying on voluntary insurance, described above, two states have enacted taxes designed to share financing with employers as part of larger strategies designed to make health coverage universally available.

'Oregon's tax data system aggregates all credits, so this credit cannot be identified.

[2] This distinction raises equity concerns: should the state reward firms that did not previously insure but not those that struggled to do so. Since about 60 percent of small firms do offer insurance while 40 percent do not, the budget impact of a tax credit for all insuring firms has discouraged states from offering it more broadly.

Massachusetts was the first state to adopt a "pay or play" law,[3] requiring that in January 1992 employers of six or more employees will pay a tax of 12 percent of payroll (up to $14,000 per employee per year, or $1680) to fund a state health insurance program. An employer that offers insurance may credit its cost against the tax. Thus, the employer must "pay" the tax or "play" in the insurance market. New and marginally profitable firms are to be protected from unaffordable taxation by special hardship exemptions (Sager et al., 1989). Due to controversy about public and private funding of the state plan and other public programs, the legislature passed a one-year delay of the program (to 1993). Although the former Governor vetoed a 1990 effort to delay implementation, his successor has proposed repealing the law, so the fate of this tax/credit approach to employer insurance is in doubt.

Oregon enacted a law similar to the Massachusetts pay or play program in 1989. The well-publicized "priority-setting" bill for lower income Oregonians has generated most of the publicity. Less notorious was a tax-plus-credit employer incentive bill establishing a state purchasing pool to offer low cost insurance to small employers, for which they can receive an income tax credit. If by October 1993 the pool and credit do not enroll at least 150,000 people, a pay or play approach takes effect. The state will then impose a tax on all employers equal to 75 percent of the cost of covering employees and 50 percent of the cost of covering dependents with a basic benefits package (to be related to the benefits under the Medicaid priority-setting process described in Chapter VIII). These tax revenues will fund a state pool for the uninsured. Employers offering insurance can credit its cost against the tax. The law offers special provisions for new and marginally profitable firms. To increase affordability of insurance to small firms and assist some uninsurable residents, the state also enacted a high risk pool.

Impact of the "Pay or Play" Approach

Although the Massachusetts and Oregon programs purport to cover most state residents, they are voluntary for unemployed individuals who may not buy into the state program if it is not readily affordable. These programs also will not cover many part-time employees or dependents of full-time and part-time workers (other strategies to do so are described in Chapter VIII).Under the Oregon law, if 150,000 workers in small firms are insured by 1993, there will be no pay or play tax, but this focus disregards the many uninsured workers in larger firms. It is also unclear whether the 12 percent Massachusetts payroll tax will suffice to fund insurance for all those in the state who want to buy subsidized insurance from the state pool (the tax rate increases after 1992 at the rate of increase in the cost of health insurance in the state). If employers are paying much more than $1,680 per employee for insurance on the private market when the program takes effect, it may be cheaper to pay the tax and drop insurance coverage, leaving the state with a potentially large and uncontrollable insurance obligation.

[3] The pay or play strategy was part of a broad set of public programs and insurance subsidies described in Chapter VIII.

An equally uncertain question is how the courts will view the pay or play tax strategy under ERISA.

ERISA **implications of** Tax **Credit Initiatives**

The scope and impact of ERISA is of great importance to policy makers attempting to provide strong incentives for employers to offer health insurance. While it is clear that ERISA prohibits an explicit employer mandate, the courts have not yet signaled how far a state can go to encourage employer action. But they may soon have the chance: The Massachusetts Restaurant Association filed suit against the pay or play law in late 1990. A brief treatise on ERISA and potential judicial interpretation of the tax incentives should help policy makers consider these risks in order to design programs as likely as possible to overcome an ERISA challenge. More detailed legal analysis can be found in Appendix III.

ERISA was enacted in 1974 to reform pension fund management, but its broad jurisdiction includes employee health benefit plans. With the exception of requiring that employee plans include COBRA continuation provisions (see Footnote 5, Chapter IV), ERISA does not regulate health plan content. And the statute's pre-emption clause, Section 514, also limits states' ability to regulate the content of health or other employee benefit plans.

Section 514(a) provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.. . "(emphasis added). State laws are defined as those "purporting to regulate terms and conditions of employee benefit plans. " Exceptions to pre-emption allow Hawaii to implement its employer mandate and all states to legislate in several areas, such as insurance regulation and Medicaid secondary payor programs. Thus, it is clear that states can regulate health insurers (e.g., mandate benefits insurers must offer), effectively regulating the content of insured health plans. But states cannot regulate health plans directly. Since over half of insured Americans work in firms that have become self-insured and the trend to self-insurance continues, the scope of state health insurance regulation has diminished (Gabel, 1988).

Over the last decade, many courts have interpreted the definition of employee benefit plan and the pre-emption clause. Of most relevance to policy makers considering tax incentive schemes are cases examining what types of state activity "relate to" employee benefit/health plans. The Supreme Court, which has never heard fully a health plan case,[4] has indicated that ERISA is deliberately expansive and pre-empts any state action "bearing

[4] The Court affirmed Standard Oil Co. v. Agsalud, 442 F. Supp. 695 (N.D. Cal 1977), aff'd 633 F. 2d 760 (9th Cir. 1980), affd mem. 454 U.S. 801 (1981) without an opinion. It interpreted the statutory insurance exception to pre-emption in Metropolitan Life Insurance Co. v. Massachusetts, 471 U.S. 724 (1985), where it upheld Massachusetts' insurance mental health benefits mandate on insurers (not employers).

upon"[5] or having "a connection with or reference to"[6] employee benefit plans.[7] Courts have tended to read ERISA jurisdiction and the pre-emption clause very broadly and its exemptions narrowly.

While generally following the broad pre-emption interpretation, a few lower courts have applied the Supreme Court's dictum in Shaw v. Delta Air Lines that some impacts of state action may be "too tenuous, remote, or peripheral" to be pre-empted. For instance, a federal appeals court held that New York's hospital rate-setting law was not pre-empted even though it increased a self-insured health plan's cost of doing business because it was not designed to "affect the structure, administration or type of benefits provided by an ERISA plan."[8] Another appeals court upheld a municipal tax ordinance that refused to exempt an ERISA medical income spending account from taxable income.[9] The court there said that in order to avoid pre-emption, a state law must be a traditional exercise of state authority (e.g., tax law), affect relations only between an outside party and either the employer, the plan, the fiduciary, or employees but not among all four, and have an incidental effect on the plan.

From a detailed reading of ERISA cases (See Appendix III), we can conclude that:

- States cannot mandate that employers provide health benefits or insurance.
- States cannot directly regulate employee health plans.
- States cannot impose premium taxes on self-funded plans or require them to participate in high risk pools.
- States can regulate insurers, including stop loss carriers but cannot regulate self-funded plans, even those using stop loss insurance.

Impact on Income Tax Credit Laws

Though employer income tax credits for purchasing health insurance are modest positive incentives, they could face an ERISA challenge. Under a technical reading of ERISA, all these laws, which define the amount of employer contribution and in some cases the types of plans that qualify for the credit, do appear to "relate to" the terms and conditions of

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[5] Alessi v. Raybestos-Manhattan, Inc. 451 U.S. 504, 525 (1981).

[6] Shaw v. Delta Air Lines, 463 U.S. 85, 97 (1983).

[7] The Supreme Court reaffirmed this position in late 1990 in FMC Corp. v. Holliday, No 89-1048, Nov. 27, 1990.

[8] Rebaldo v. Cuomo, 749 F. 2d 133, 139 (2d Cir. 1984, cert den. 472 U.S. 1008 (1985).

[9] Firestone Tire & Rubber Co. v. Neusser, 810 F. 2d 550 (6th Cir. 1987).

employee health plans. It is possible that a court would find their relationship to health plans peripheral. If a state could argue that the purpose of the law was merely to reward, rather than to influence, employer activity (a practical if not intentional effect), a statute might survive a challenge. As a practical matter, the chance that an employer denied the credit (perhaps because he or she already offered insurance) would actually go to the cost and trouble to file a suit is small. But the theoretical problem remains.

Impact on Pay or Play Taxes

State "pay or play" tax-plus-credit laws, where the financial consequences to an employer are greatest, are most likely to face an ERISA challenge, as has already occurred in Massachusetts. A pay or play model seems to stand the best chance of withstanding an ERISA attack if:

- The explicit legislative purpose of the program is not indirectly to require employers to insure their workers but to establish a state health care financing program and to provide an employer tax credit because the employer is relieving the state of this financing burden;

- The tax is set out in the law as a fixed dollar amount or percentage of payroll (possibly adjustable for inflation) to generate the revenue a state needs to fund its public program, not calculated specifically as the cost of a particular benefit package; and

- The tax credit is not conditioned on any definition of acceptable levels of benefits employer contributions to an employee plan, or other administrative requirements.

By these criteria, it seems possible that both the Massachusetts and the Oregon laws could withstand an ERISA challenge. An important caution to states willing to confront the considerable political challenges presented by a pay or play strategy is to keep both the bill language and its statement of purpose consistent with legal requirements. Well-intentioned bill sponsors who characterize this model as an "employer mandate" do not help the Attorney General defend the law later.

Some states such as Minnesota, California and Massachusetts, have requested ERISA waivers like Hawaii's 1983 exemption. Congress could obviate the ERISA limitation entirely by imposing a federal employee insurance mandate as proposed by the Kennedy-Waxman bill or a "pay or play" requirement as proposed by the Pepper Commission. Pending such federal legislation, rather than attempting to chart ERISA's murky waters, some states believe that Congress should amend ERISA to permit the type of solution that a few states, at least, would be willing to tackle.

Chapter VI New State Regulatory Strategies

Introduction

Several states have moved actively into the arena of insurance regulatory reform as an alternative or supplement to the development of new public strategies to expand access to health care. There are several reasons for this new interest. First, regulatory reform offers an opportunity to attempt to broaden coverage without a commitment of new public dollars. These "no cost" options have a strong appeal in an era of fiscal restraints. Second, with the growth of the small business sector has come a greater appreciation of the importance of the small group market to strategies to expand health coverage. This segment of the market experienced serious difficulties during the 1980's. Prices rose disproportionately, many insurers took substantial losses, and a significant number of insurers pulled out of the market altogether. Those who stayed have adopted increasingly defensive and aggressive medical underwriting and screening practices. State policy makers are faced with the need to rely more heavily on the small group market for coverage of constituents at the same time that the market is becoming increasingly volatile and restrictive.

As a consequence, new laws are emerging that reflect an effort to expand the scope of private small group coverage through limitations on insurers' authority to screen out individuals, restrict coverage or differentially price insurance policies.

Historically, pricing and screening practices have not been subject to very much regulatory scrutiny. About half the states require prior approval by the Insurance Commissioner of rates for non-group policies and Medicare companion plans. Beyond this, although regulatory policy varies from state to state, for the most part insurers need only "file and use" initial and renewal rates (have rates on file with the Insurance Commissioner prior to marketing) or "use and file" rates (a grace period after going to market, to submit rates to the regulatory agency). Even in states that do review and approve rates, the extent of this scrutiny varies. In some instances, insurers must submit loss ratio reports and rating formulas, and proposed rate increases may even be subject to a public hearing. In many instances, rates are deemed approved thirty to sixty days after filing, unless the insurer is otherwise notified, and review may be cursory.

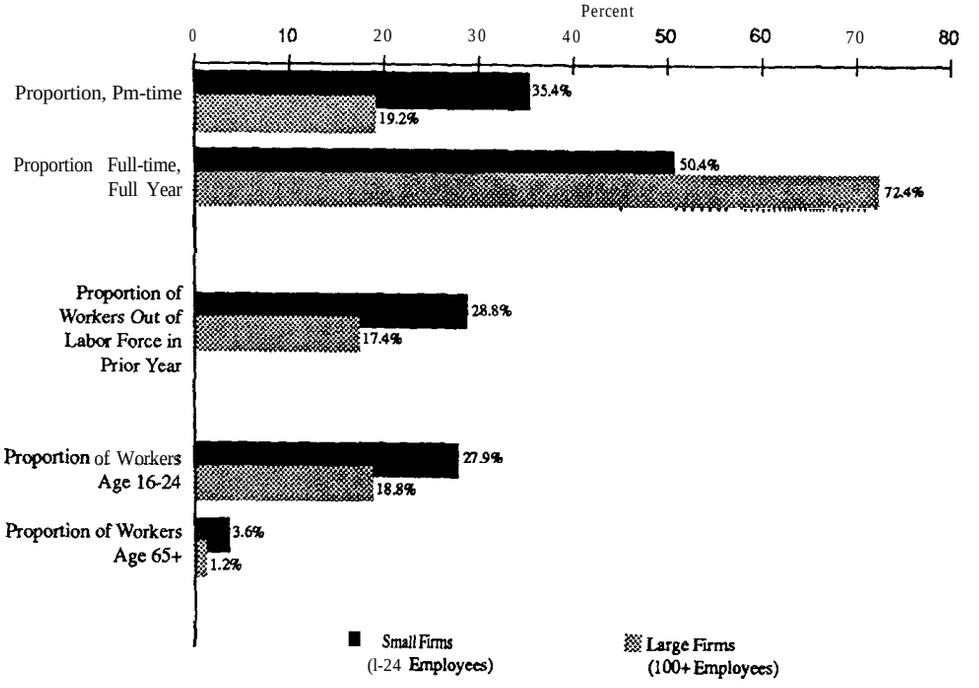
Further, until recently, states have not tried to establish norms within the industry regarding eligibility or pre-existing condition limitations. States have limited their oversight of health insurance rates to individual coverage policies based on the assumption that competition will act to regulate price and quality in the group market.

In the small group market, competition is indeed fierce. However, this competition has evolved in ways that were unanticipated. The small group market is, by nature, volatile. New businesses start up and fail at a rapid rate. In normal economic conditions, employee turnover is high. Many businesses (building contractors, retailers in tourist areas,

restaurants, inns, etc.) are seasonal or cyclical in nature. Many employ part-time workers, and are more likely to have very young or very old workers (Figure 5). Further, many have little or no profit or extra capital in the early years of operation. Because these factors lead to a rapid entry and exit within the insurance market, insurers have turned the art of identifying and attracting good risks into a science. Insurers who can hold down their costs by writing a larger than average number of healthy non-users and screening out potentially heavy users are clearly at a competitive advantage. This shift in competition from product modification and risk distribution to risk avoidance has led to the practices described below.

Figure 5

Comparison **of Employment Characteristics Nationally, of Small Firms and Large Firms**



Source: The State of Small Business, 1987, pp.231-245.

Small Group Insurance Market Practices

Medical Underwriting

The practice of requiring extensive health history questionnaires or, in some instances, actual medical exams, used to be limited to applications for life insurance and non-group health coverage policies. Some insurers in the small group market are now extending this practice to groups as large as fifty or more.

When high risk individuals within groups are identified in this manner, insurers may respond in a number of ways. They may refuse the individual but offer to cover other applicants in the group (38 states have "all or nothing" laws precluding this practice); they may temporarily or permanently exclude a pre-existing health problem from coverage (see pre-existing condition limits, below); they may adjust their proposed premiums to cover their expected exposure due to the high risk condition; or they may refuse the entire group. When the group is small, any upward adjustment in premium is borne by a limited number of policy holders rather than being spread across a larger pool of insured individuals. The resulting premiums may be exorbitant and preclude coverage for all but the most affluent firms.

These practices result in direct exclusions and financial barriers both for individuals and entire small businesses. In addition, they encourage brokers and employers to pressure individuals with high risk conditions to "voluntarily" withdraw from the group so that the rest of the group can attain affordable coverage.

Pre-Existing Condition Liiitations

Most small group and non-group insurance policies preclude coverage of care related to medical conditions which predated the purchase of the policy. These exclusions are usually limited to a twelve month period (but periods as long as 36 months exist), after which the policy holder regains full coverage. Some limit the exclusion to conditions which were diagnosed or treated within six months to two years prior to the policy's commencement date.

These pre-existing condition limitations serve the important function of discouraging individuals from waiting until they are sick to buy coverage. Obviously, if only those who are actively using services are paying premiums, the insurance fund will quickly be dissipated. Unfortunately, pre-existing condition limitations can also have negative effects. They encourage individuals to delay seeking treatment while a condition grows more serious, resulting in more lengthy, complex and expensive interventions. Further, because they delay rather than eliminate the claims exposure of the insurer, they encourage insurers to use a "select and ultimate" rating scheme, where one rate is offered to new business with pre-existing clause limitations, and a higher rate is applied to renewals, reflecting the anticipated or actual "ultimate" claims experience of the pool. Businesses faced with very large rate hikes upon renewal will seek coverage elsewhere, only to face substantial price increases in a year or two. This cycle results in substantial churning in the market, and makes individual employees with chronic health problems vulnerable to sequential waiting-period limitations, precluding coverage of their conditions for years or indefinitely,

Tiered Rate Structure

Many insurers in the small group market combine a "select and ultimate" rating with a tiered rating structure. In these situations, rather than pooling the ultimate claims experience and charging all renewals a uniform increase, the pool is segmented into two or three layers based on claims experience and projected risk exposure, and each segment receives a corresponding rate. This approach is intended to protect low user groups from experiencing high rate increases (and the insurers from losing their business). Again, however, segmentation of the pool results in very high rates for small groups with health care needs, frequently driving these groups out of the market.

Manual Rating

Most insurance in the small group and individual market is manually rated, i.e., priced differentially based on the age, sex and area of the subscribers. These differentiations are substantial with women in the child-bearing years paying approximately double the rates of their male counterparts, if the coverage includes maternity benefits; and a fifty-year old male paying approximately double the rate of a twenty-five year old male.

Manual rating, according to the terms of the insurance industry, creates "premium equity" and avoids cross-subsidization. To the extent that health care expenditures can be predicted, each subscriber pays proportionately what he or she can be expected to use in health services. This strategy makes it easier to attract the subscriber that insurers want - young, single individuals (especially men) who can be expected to use health services infrequently. The converse effect of this rating strategy is that the cost of coverage to older individuals and women is very high, regardless of health status. A small business with a few older employees or with a predominately female work force may find health insurance financially out of reach.

Industry Screening

Insurers have developed industry screening as a short-cut to medical underwriting. Based on their own experience, another insurer's experience or industry folklore, most insurance companies in the small group market have developed lists of businesses classified by the type of work, for which they will not write policies. Some businesses are on these lists due to occupational hazard (pesticide application, small aviation firms, heavy equipment operation); some because employment tends to be seasonal or unstable (restaurants, motels); some because they are traditionally heavy users of health care services (physician offices and other direct service providers); and some because the group is loosely formed, may be financially unstable or possibly subject to exploitation by relatives or friends with health problems and no other source of health care coverage (volunteer organizations, non-profit agencies, etc.). These screening practices limit access to coverage for those working in one of the suspect industries, regardless of health status or ability to pay.

The combined effect of these measures is to hold health coverage costs down for the young and those with no history of illness. For others, these measures can result in significant barriers to coverage. A small employer with an employee who develops a heart condition or similar problem may face premium increases as high as 300 percent. Yet, if this employer looks for alternative coverage, he or she knows the employee will be rejected or face coverage limitations that restrict access to his or her most pressing needs or that the whole group will once again face extremely high premiums. Similarly, an individual employee within the small group market loses job mobility if he or she (or a dependent) develops a health problem because of the prospect of medical underwriting or pre-existing condition clause limitations likely to accompany any new coverage options.

A number of states have passed or are considering laws that place some constraints on these practices. In addition, the National Association of Insurance Commissioners (NAIC) has developed model legislation providing guidelines on some practices and the Health Insurance Association of America (HIAA) has developed recommendations for risk redistribution, continuity of coverage and rate reform in the small group market that are intended to broaden availability and provide more equity in pricing.

New Regulation Strategies

Limiting Eligibility Restrictions and Screening

Pre-existing Condition Exclusions

Several states have acted to limit insurer use of pre-existing condition exclusions for successor insurance policies. **Connecticut, North Carolina,** and **Maine** have passed laws that limit the duration of waiting periods for coverage and preclude the imposition of new pre-existing condition exclusions if the group changes policies. Any successor plan must give credit for the portion of the waiting period met under the prior plan. North Carolina and Connecticut allow a maximum waiting period of twelve months, Maine of 90 days.

These laws make health insurance a transportable benefit in the small group market for an individual with a chronic condition, either in the situation where the employer changes plans or where the individual, due to a job change, moves from one group coverage plan to another. The laws are also intended to minimize churning, since premiums available to the group are likely to be more uniform across carriers once the pre-existing condition limits have been met.

Maine has carried the continuity of coverage concept one step further and precludes waiting periods for those transferring from individual policies to group policies, Continuity of coverage (precluding the imposition of waiting periods or exclusions) is mandatory for any individual who had coverage through an insurer, HMO or governmental program such as Medicaid within ninety days prior to joining the successor group plan. This provision was

adopted on the theory that persons, once "in the system", should have assurances that their coverage is renewable, regardless of changes in job or location.

Insurers have raised concerns that this provision opens the door for individuals who will buy inexpensive plans that offer very little coverage, and can then transfer at will, without waiting periods, to much more comprehensive group plans when they develop a health problem. To counter this concern, a task force in Maine is developing language that would limit the continuity of coverage provisions to individual policies that met minimum benefit level requirements.

Medical Underwriting Limitations

At least three states (New **York, North Carolina,** and **Georgia)** have banned individual medical underwriting for groups larger than a specified size. In North Carolina, the limit is 50 employees; in New York it is **300.** For multiple employer trusts, the limit is applied to the individual participating employer groups, not the trust as a whole.

Medical underwriting, because of its administrative cost, used to be limited to very small groups. The trend in recent years has been toward its application in larger and larger groups, as is evidenced by state actions to limit this practice. The concern, of course, is that the preemptive identification and exclusion of health problems denies coverage to precisely those who need it the most. This concern is not limited to the small group and individual insurance markets; there is growing evidence that some large employers, whether self-insured or experience-rated by an insurance carrier, are translating concern over rising health benefits costs into health screens at the time of employment application. Self-insured employee benefit plans are beyond the reach of state insurance regulation, but some of these practices are being challenged in court under anti-discrimination theories.

Coverage of Part-Time Employees

Laws in New **Hampshire** and **Vermont** require insurers to make similar coverage available to part-time workers (who work, on average, a minimum of 17.5 hours per week) in all group plans where coverage is offered to full-time employees. The law is binding only on the insurer; employers still have the option to exclude part-time workers. Further, no specification is made as to premium contribution. The employer may offer the benefit, but is not required to contribute toward the cost.

Insurers have frequently precluded coverage of part-time workers because of the fear of adverse risk selection. A small firm employer may place a relative or friend on the payroll for minimal hours just to obtain coverage. Even absent any "gaming" of the system, if an employer does not contribute to or contributes only a pro-rated share of the premium, it is likely to be those part-time workers most in need of health services who are willing to shoulder the additional costs.

These laws, because they place no mandates on the employer and place heavy cost burdens on the employee, are likely to have little impact on the coverage of part-time workers. Employers, like insurers, have a direct interest in avoiding adverse risk selection since it will raise their rates.

In 1990, Vermont and New Hampshire both attempted to introduce laws to require *employers* to offer permanent, part-time employees the option to participate in their group plan at the group rate. No employer premium contribution was required. These bills were strongly opposed and defeated by employers, both because of the concern with adverse risk selection and because they saw the proposal as a foot in the door to mandated employer health benefits.

Regulating Rating and Price Strategies

The new laws described above address access problems imposed by current insurance eligibility restrictions. These laws do not attempt to address financial barriers to insurance coverage. There is some danger, in fact, that these reforms will increase financial barriers for some in the small group market since they broaden coverage for potentially costly conditions. The gain in coverage is questionable if, by removing pre-existing coverage limitations on a sub-set of employees, entire small businesses are forced to drop insurance altogether due to cost.

The issue of how claims experience costs are distributed in the small group market is currently being addressed by a small number of individual states, and nationally, by NAIC and HIAA. To date, most states have taken limited action to correct perceived abuse in setting rates. These reforms include:

Limiting post-claims experience underwriting

North Carolina has passed a law that precludes an insurer from underwriting a group or a multiple employer trust at the point of contract renewal or during the term of a contract. This statute stops the practice (fortunately, not wide-spread) of post-claims underwriting in an effort to eliminate bad risks from an already covered group.

Limiting sub-groups within multiple employer trusts

Georgia and **Texas** require the experience of employer groups within multiple employer trusts to be fully pooled for rating purposes. The experience of sub-groups or individual businesses cannot be used for rating or as grounds for termination.

Establishing relative premium pricing limits

Maine currently limits the spread of rates used by an insurer in the small group market.

The highest rated group within an insurer's small employer line of business cannot be given rates more than 20 percent above the average of all the groups within that line of business. In New **York,** insurance regulation limits rate increases for health risk factors to 50 percent above what would otherwise be charged. These limitations attempt to prevent the use of exorbitant rate quotes as a way of effectively terminating some small groups. It may also provide some cross-subsidization among sub-groups, keeping premium costs somewhat more equitable across the market.

Limiting renewal rate increases

New York precludes using claims experience as a factor in setting rates until the group life years have reached fifty. In other words, a group of ten persons could not be experience rated until after its fifth year with a carrier while a group of twenty-five could be experience-rated after two years. In addition, New York prohibits the use of claims experience in establishing renewal rates if evidence of insurability was used in determining the initial premiums (or in determining whether or not to underwrite the group). Thus insurers in New York have a choice between initial medical underwriting or using claims experience for renewal rates (with a maximum mark-up of 50 percent).

Comprehensive Small Group Market Reform Proposals

Concerned with the dysfunctions of the small group market, both HIAA and NAIC have developed or are developing comprehensive proposals designed to substantially increase availability of coverage, stabilize premium rates and distribute risk more broadly. These proposals combine guaranteed issue and renewal, continuity of coverage provisions, underwriting, and rating reforms, and reinsurance mechanisms designed to protect insurers from losses and small group pools from significant and rapid deterioration. **Connecticut** has already enacted parts of these recommendations.

Proposed Underwriting and Rating Reforms

The HIAA and NAIC proposed reforms have several features in common. Both advocate whole group coverage (an insurer cannot deny coverage for an individual within an applicant group), both guarantee renewability (an insurer cannot drop a group at the end of a contract period, due to claims experience), and both advocate guaranteed continuity of coverage (with no newly imposed waiting periods) within the group market for the individual or group that changes policies. Under the terms of these proposals, an insurer could refuse to renew coverage only in cases of non-payment of premium, fraud, where a firm's size drops below eligibility levels, or if a firm is no longer conducting the same business as at the time of coverage. As is currently the case in Connecticut, North Carolina and Maine, coverage would become a transportable benefit, from group plan to group plan.

Both proposals also place limits on discretionary rating practices, but differ somewhat in the specifics of their recommendations. Under the HIAA proposal, insurers could vary by as

much as 35 percent from a mid-point, the rates offered to demographically and geographically similar groups, based on underwriting criteria. Insurers could vary rates by industry type but not by more than 15 percent from a mid-point rate (see example, Footnote 2, page 65). NAIC recommends a 25 percent rate band for groups with similar case characteristics and a 20 percent variation between different classes of business. Class of business distinctions under the NAIC proposal are allowed for lines of business acquired from other carriers, multiple employer associations, guarantee issue groups, and products sold by distinct marketing and sales representatives or organizations. Roth proposals also place limits on the increase at renewal allowed for claims experience, basically allowing 15 percent on top of general inflation and any changes due to benefit modification.

In addition to these rating restrictions, the NAIC proposal precludes a number of practices that might allow an insurer to "game" the proposed system. Under this proposal, the insurer could not transfer a group involuntarily from one class of business to another. Similarly, the insurer could not offer a transfer to some groups within a class unless a similar offer was made to all groups, without regard to claims experience, health status or demographics. If an insurer drops a line of business, it cannot establish a new line for five years without prior approval from the insurance commissioner; and it cannot transfer some groups from the defunct line without offering similar coverage to all groups within that line. This proposal, in other words, precludes practices that allow insurers to weed out or differentially rate the groups with the worst experience, except within the range established by law.

Risk Distribution Proposals

To offset the potential risk associated with these reforms, HIAA has proposed a reinsurance arrangement that would protect individual insurers and spread the risk associated with the voluntary small group market broadly across the industry. A reinsurance organization would be established in which memberships would be mandatory for all insurers doing business in a state. Through this mechanism, insurers (not employers or individuals) would purchase reinsurance either for entire groups deemed to be high risk, or for individuals within groups. Premiums for groups would be capped at 150 percent of average market premiums and at 500 percent for individuals. Like state high risk pools, the premiums would not be expected to cover the claims experience of the reinsurance program, and additional funding would be secured through a proportional assessment (of four percent of premiums collected) on all carriers in the small group market, and if necessary to meet the pool's fiscal requirements, a one percent assessment on other health insurance plans..

The purchase of reinsurance would be negotiated between the primary insurer and the reinsurance organization. The high risk individual would maintain the same benefits through the same policy as the rest of his/her employment group (and not be required to purchase a separate policy through the High Risk Organization as is the case with current state High Risk Pools). Eurther, insurers could not pass through the entire cost of the reinsurance in

the form of premium increases to the affected individual or group, but rather would be limited to the 35 percent or 25 percent rating band ceiling described above.

NAIC is currently studying five different risk distribution strategies. Two of these strategies would be coupled with guaranteed issue requirements (i.e. insurers would be required to write policies for all applicants within eligible categories, without regard to health status). The proposals under study include: prospective reinsurance where, like the HIAA proposal, high risk groups are initially identified through medical underwriting and reinsurance is purchased through the pool; retrospective reinsurance where the pool provides stop-loss coverage of claims above a certain amount; an allocation model where high risk groups would be equitably distributed among carriers; a pooled employee option where small groups would be aggregated into benefits programs and treated as a single group for insurance purposes (like a multiple employer trust); and a designated carrier option where, like current state high risk programs, a designated insurer would administer a coverage program for high risk groups under contract to the reinsurance program.

No state has adopted either of these reform packages wholesale. However, **Connecticut** included many features from these proposals in its comprehensive health care access legislative package enacted in 1990. Encompassed in Connecticut's law are guaranteed issue provisions, guaranteed renewability, limitations on pre-existing conditions with continuity of coverage in successor plans, and required whole group coverage. Connecticut has also limited rating bands based on medical underwriting and claims experience with limits similar to the HIAA proposal. A phase-in period is allowed for existing coverage policies. In keeping with the recommendations from the HIAA, Connecticut has created a reinsurance program with mandatory participation by all insurers in the state. Insurers contribute to pool losses through a five percent assessment on their small group premiums. This assessment, if insufficient, can be supplemented by an assessment on all health benefit premiums generated in the state.

Connecticut has supplemented this small group market reform with special coverage programs for currently uninsured and low-wage small firms. Each insurer participating in the small group market is required to offer "special health care plans", designed to make transitional affordable coverage available to currently uninsured small businesses (see description, Chapter VII). Connecticut is also using the reinsurance organization to administer an even lower cost coverage plan to small businesses with ten or fewer employees, the majority of whom have wages below 200 percent of the poverty level.

Mandatory Community Rating

The rating reforms proposed by the Associations and adopted in Connecticut may broaden availability, stabilize premiums and slightly narrow the variation in price in the small group market. These proposals, however, continue to allow substantial variation in premium rates.

None does away with age/sex rating bands.[1] And even for persons with similar age/sex characteristics, the range between lowest and highest allowable rates (taking into account allowable variation for industry classification and risk characteristics) is substantial.[2] The combination of these factors can result in maintaining prohibitive differences in rates for older men or women, particularly those with prior health problems or employed in "hazardous" industries.

An alternative model for comprehensively restructuring the small group market is under consideration in at least three states (New **York, Maine** and **Vermont). These** proposals suggest that differential rating based on any factors other than geographic location be eliminated altogether and that denial of coverage based on health status be banned in the small group and individual market. Under these proposals, all insurers in the market would face similar risks because no one carrier would be in a position to screen out bad risks. The claims experience of all individuals and groups would be pooled and all would receive similar rate increases.

This guaranteed issue, community-rating model is currently found only among some Blue Cross/Blue Shield plans and some federally qualified HMOs, where it is fast disappearing. Those plans that have guaranteed issue or community-rated in the past had pools that deteriorated and required substantial increases in premiums when faced with the competition of screened, low-risk groups that could offer advantageous rates.

The argument put forward with these new proposals is that with "a level playing field", no one insurer should experience pool deterioration, and equity in cost of coverage would be maintained in the small group market.

Community rating is attractively uncomplicated. It eliminates the need for costly and administratively cumbersome medical underwriting and complex actuarial rate adjustments among different lines of business. Some argue that it also accomplishes a socially desirable goal of broadly distributing health care costs across a large population base without penalizing individuals for their health status, age or sex.

The major concern regarding community rating is that the premium necessary to cover the claims experience of the community pool, including all those with expensive health

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'Typically, a bealthy fifty year old man may be charged double the premium of a healthy twenty-five year old man in manually rated policies, and a woman will have premiums 40 percent higher than a man of the same age - in a plan without maternity coverage.

[2]An example of possible premium spread among individuals with similar case characteristics under HIAA's proposal is as follows: Allowable variation in monthly premium based on industry classification (15 percent variation) - low, $127.50; midpoint, $150.00; high, $172.50. Highest possible premium (35 percent above high risk business group midpoint) - $232.87. Lowest possible premium (35 percent below low risk business group midpoint) - $82.87. Spread between lowest premium and highest premium among individuals with similar case characteristics - 280 percent.

conditions, would be very high, encouraging the young and healthy to go without coverage. In other words, the community pool might suffer the same deterioration experienced by individual insurers who have not aggressively applied medical underwriting criteria. In a voluntary market, where individuals and employer groups can choose whether or not to purchase coverage or to self-insure, it is difficult to assure broad participation with a costly product.

These concerns are real, although it is difficult to predict with any accuracy the likely impact of either the rating reforms proposed by the Associations or the community-rating proposals. Since all these proposals remove barriers to potentially high cost users, the median coverage cost under each plan is likely to rise, driving some from the market. It is unclear how many currently insured will drop out of the system when faced with price increases, especially if lower cost coverage is not available elsewhere.

HIAA and some of the other state-specific proposals suggest counter-balancing these potential increases in cost with reductions in the scope of benefits as a means of lowering premiums. The pros and cons of benefit reductions are discussed in Chapter VII. Some of the proposals are also coupled with mechanisms that shift some of the costs of the small group market more broadly across the insured population, such as the HIAA model's proposed assessment of all insurance carriers to fund the reinsurance program. One proposal in Maine contains a feature that would entitle any carrier offering a guaranteed issue, community-rated product in the small group market to a substantial hospital discount on all claims generated by their small group line of business. Since the hospital losses for these discounted services would be passed on to other hospital payors, this feature would constitute an indirect assessment on all other insurers and payors.

Whatever the mechanism - reduced benefits, a reinsurance program, a hospital discount, employer tax credits or direct subsidies - states may want to consider ways of linking reforms of the small group market to strategies designed to bring down insurance prices. The "no-cost" options available to states may not be no cost after all.

Chapter VII Private Sector Initiatives

Introduction

Private health care providers have traditionally responded to the needs of uninsured and low income people throughout the country. Hospitals, physicians, and other practitioners render millions of dollars of charity care to individual patients (Fraser, 1988). In some communities medical societies or non-profit clinics have organized formal private sector referral networks. These programs often coordinate with local government and public health activities. In the last few years some insurance carriers have developed innovative programs in several states that either directly fund children's health care or make lower-priced health insurance available to small firms. In most cases these programs developed independent of any public involvement but some were fostered or enhanced by public funding or regulation. As discussed in Chapter IV, Blue Cross plans with "open enrollment" (i.e. guaranteed issue without medical underwriting) and the high risk pools financed by assessments on insurers and HMOs without a tax credit also represent ways the private sector finances health care for people who would otherwise be uninsured. For example, Blue Cross of California recently began voluntarily accepting one small group previously rejected due an to employee medical condition for every five standard groups, at rates **30** percent higher than standard groups.

The private sector, is also responding, independent of public initiatives, to the need for lower cost insurance products. These efforts are for the most part directed toward alternative benefit configurations, increasing cost sharing and eliminating some "non-basic" services, such as mental health.

States have responded to these initiatives in a variety of ways, ranging from regulatory changes to encourage such developments, to the initiation of public/private partnerships (eg. **Michigan's** Medicaid/Blue Cross children's plan, Chapter II), to some instances of resistance to relaxing mandated benefits.

Blue Cross "Caring Foundation" Plans

Following the 1985 example of Blue Cross of Western **Pennsylvania,** Blue Cross Associations in ten other states have developed private sector programs to subsidize outpatient health services for low income children (Appendix, Table A). These programs, which look like "insurance" to enrollees, but which are generally treated by regulatory agencies as charity care programs, vary slightly but generally serve children under age 19 in families ineligible for Medicaid but with incomes under the federal poverty level. Most programs cover only completely uninsured children, not children whose insurance has high deductibles or does not cover well child care (although as noted in Chapter II, about 30 percent of the children enrolled in **Minnesota's** Child Health Plan have group insurance but need supplemental coverage for ambulatory care). As Medicaid eligibility has recently increased, some of the Caring Foundation programs have raised eligibility standards to 133

percent of poverty. Families pay no enrollment fee, though in some of the programs that offer drug benefits they pay a $1 to $3 copayment per prescription. To spread risk, some programs require that all eligible children in a family enroll.

The programs cover outpatient care, preventive services (well-child visits, immunizations), acute care (visits for illness, accidents) emergency services, diagnostic (lab and x-ray) services, and outpatient surgery. A few of the programs offer prescription drugs. Inpatient services are not covered. Providers are primarily physicians in the Blue Cross/Blue Shield network and hospitals for outpatient and emergency care. Physicians are generally paid their normal Blue Cross rates (often a discount off usual and customary charges).

Caring Foundations are private non-profit corporations funded through philanthropic donations. Civic groups, churches, and other organizations are encouraged to "sponsor" a child or family. All Blue Cross Associations donate administrative costs for staff and claims processing. Some also match private donations to fund the health care services, whose costs range from about $200 to $300 per child per year. The state of **Iowa** appropriated $300,000 in start-up funds in 1989 to match private contributions for the Caring Foundation program in that state. Blue Cross of Western Pennsylvania has the largest enrollment among Caring Foundation plans - 6,000 children (15 percent of the estimated eligible population) who remain on the program an average of about 19 months.

Because they are designed to supplement Medicaid, Caring Foundation programs require potentially eligible children to apply for Medicaid before applying to the Foundation. Through their outreach and public relations efforts, some plans have identified a large number of Medicaid-eligible children. Thus they can' be an important Medicaid screening agency with which state Medicaid programs could coordinate.

Several Caring Foundation plans have begun in the last year, and it is possible that this model will spread to other states. State agencies can play a role in encouraging such programs to develop. Even if they cannot offer matching funds, they can arrange to share publicity and outreach activities. A close relationship between the Medicaid eligibility staff and the Caring Foundation staff that processes applications is important to assure that each program plays its appropriate role and that maximum federal matching is achieved in order to serve as many low income children as possible.

Modified Health Insurance Products

In its earliest form, health insurance was designed to indemnify subscribers against the costs of catastrophic illness by covering hospital, surgical, and accident benefits with a large deductible. Such catastrophic coverage plans are still available from some health insurers. For instance, Blue Cross plans in several states market a "Basic" plan of hospital, surgical, sickness and accident benefits (often with obstetrical care) with high cost sharing and lower than normal annual and lifetime limits. However, catastrophic coverage is not the norm and appears to have limited appeal, especially to employer groups, whose policies generally have

low cost sharing features, increasingly broader benefits, and generous life-time maximum and stop loss provisions. Concern about the uninsured has generated a search for lower cost insurance plans that might be more attractive to small, uninsured employers than such traditional catastrophic coverage.

Benefits Under Existing Legal Authority

A few of the Johnson Foundation demonstrations lowered insurance premiums without public subsidies by such strategies as managed care, provider discounts, or high cost sharing on inpatient services but little or no cost sharing on preventive care (See Appendix II). For instance, an HMO in **Utah** reduced premiums through managed care strategies and high copayments for acute care, while one in **Tennessee** lowered costs by deep hospital discounts. The SCOPE project in Denver offers a plan through United States Life, a large indemnity carrier, that includes both a limited provider network and cost sharing for inpatient and acute care with no copayment for preventive services. These plans cover catastrophic costs (e.g., full coverage after $2,500 in out-of-pocket expenditures on acute care) while providing first dollar coverage for preventive services that young families may need (eg. full coverage for all recommended well-child visits in the first five years of life and immunizations). Such a plan design is attractive because subscribers feel that they can use the plan* and are willing to pay the small additional premium for preventive benefits.

Developed specifically for currently uninsured small groups, these limited benefit products are not attractive to most currently insured firms (other than those contemplating dropping their insurance due to cost). But they fill a void in the market. They are popular and, although enrollment rates may seem modest from the viewpoint of covering the uninsured population, the insurance industry finds enrollment very encouraging. The demonstration project experience also seems to be inspiring imitation. About a year after SCOPE began marketing in the Denver area, a competitor has started marketing a similar product. Some Blue Cross plans are also developing products with coverage of specified preventive services and high deductibles. Because of high cost sharing in some of these plans, however, it could be argued that enrollees with low incomes have merely moved from the status of uninsured to **underinsured.**[2]

[1]**The** original concept of health insurance as spreading the risk of an unexpected and potentially very costly event has changed **to** a mechanism for partially prepaying the costs of health care. Thus, people often express a preference for a plan that they can expect to use, even for an extra cost, rather than one that protects them against an unpredictable and costly risk.

[2]**Low** income SCOPE enrollees are eligible for subsidies for hospital cost sharing through Colorado's Medically Indigent program.

Insurance Regulation to Expand Coverage

Required Small Group Policies

While the limited benefit products described above are emerging in states with few mandated insurance benefits, other states are attempting to encourage non-traditional plans by explicit regulation. For instance, as part of its 1990 omnibus health care financing and insurance regulation reform bill, **Connecticut** requires all insurers writing small group products to offer "special health care plans" to any firm with under 25 employees (except firms under eleven employees, a majority of whom are low income[3]) that has been uninsured for at least two years. Payment is limited to 75 percent of Medicare's rates, and the statute requires providers to accept these rates. Insurers must pay out at least 75 percent of the premium in benefits, and premiums for these plans are not subject to the state's 2 percent premium tax.

Insurance Mandate Waivers

Over 700 different types of services (e.g., mental health, mammography), providers (e.g., chiropractors, optometrists, psychologists), or prospective enrollees (e.g., newborns, adoptive children, disabled children) are covered through insurance mandates throughout the U.S. (Gabel et al., 1989). Some of these laws merely require that the benefit be offered ("mandated offering"), but most require that the benefit be covered ("mandated coverage"). In 1990 eight states enacted laws permitting insurers to offer special products to small groups (generally 25 or fewer employees) that eliminate some of the state group insurance mandates (See Appendix I, Table C). The insurance pools in **Oregon** and **Oklahoma** (participation in which entitles employers to income tax credits discussed in Chapter V) will also develop or authorize purchase of insurance that may not include state mandates.

These laws approach the issue of alternative product design in two ways:

- Some statutes, such as that in **Missouri,** permit a carrier writing small group coverage to develop policies that eliminate such services as substance abuse, mammograms, newborn coverage, home health, or hospice care.

- Other laws (e.g., in **Rhode Island** or **Virginia)** both waive specific mandates and define the minimum benefits that must be covered, such as a given number of hospital days, physician visits, and other services. Some of these laws actually add new benefits, such as prenatal and maternity care, in order to assure that they meet the needs of the younger families likely to use them.

[3] A newly created public reinsurance pool will offer a special health care plan to firms under ten with a majority of low wage employees; this plan is required to pay out at least 80 percent of premiums in benefits and operate on a "no gain/no loss" basis.

So far, insurers in **Washington** and **Virgiia** have developed products under these laws. Premiums are estimated to be 60 percent to 70 percent of the cost of full-benefits policies. Some plans include prenatal and well child care not required by state law. The products are thus far well received (New York Times, 1990). Once again, the issue of whether these limited products are adequate depends on the design of each plan and the needs of enrollees.

As most policy makers have learned, the debate over mandated insurance benefits is highly charged. Insurers and employers resist the idea of any government mandates, contending that eliminating mandates would lower insurance prices to affordable levels. Certainly many larger firms have become self-insured to avoid the requirements of premium taxes and benefit mandates (Gabel et al., 1989).[4] Providers and constituent groups argue for maintaining and expanding insurance benefits in order to assure that needed services are affordable and to spread their costs over the largest possible population.

There is no consensus on the critical issue of the cost of these mandates or even the best method to measure their costs. While some services, such as inpatient substance abuse treatment, seem likely to add to the cost of health insurance, others, such as home care or hospice care can substitute for more expensive hospital or nursing home services (Gabel et al., 1989). Still others, such as prenatal care and mammography save longer-term health care costs (Institute of Medicine, 1985; State of Hawaii, 1990). Some benefits are also thought to add to costs because they uncover other problems that need medical attention. Laws requiring that all providers legally entitled to render a service must be reimbursed if the service is offered (e.g., requiring psychologists to be paid if mental health care is covered) probably result in covering lower cost providers but appear also to increase overall use of the service among people preferring to use non-physician practitioners (Gabel et al., 1989). Still other services, such as obstetrical or newborn care, are costly but may serve an important public policy purpose and can be much less expensive if their costs are spread over a large group of enrollees rather than just people selecting the benefit or needing the service.

Consideration of "bare-bones" policies exempt from mandated benefits provides policy-makers an opportunity to consider what services ought to be available to all citizens as well as which services to cut. Several states, including **Rhode Island, Virginia,** and **Illinois**, have taken this approach and maintained mandates for such services as coverage of newborns, adopted and disabled children; well child care; and prenatal care. Other states, however, have allowed the ax to fall on such preventive services as mammography and well-child care where there are inarguable public health benefits and at least arguable potential long-term cost savings.

Policy makers should seek objective information about the costs and benefits of these requirements. States such as **Maryland** and **Maine** have enacted laws requiring a cost-benefit analysis of any proposed additional mandates--a challenging task. The arguments about

[4] This is true despite the fact that surveys of benefits offered by self-insured firms reveal that they provide the most common mandated services, such as mental health and substance abuse (Bartlett, 1990).

mandates will be better served if an objective evaluation can be undertaken of the need for each service in question, its costs, its substitution and augmentation effects, and the opportunities for managing each type of care. Most of the research on the costs of mandated benefits has been funded by the insurance industry and has tended to examine the proportion of all claims represented by mandates, which ranges from 6 percent to 21 percent, rather than the substitution and additive effects of mandates. (Ralston et al., 1988; Gabel et al., 1989; Wisconsin Insurance Commissioner, 1990)

Fortunately, it is not necessary for policy makers to delve into the entire mandated benefits controversy to encourage more variety in the health insurance market. As discussed in Chapter IV, public agencies could fund or merely foster new insurance plan development efforts. If there is sound evidence that lower cost products cannot be developed within the state's current insurance law, consideration of mandated benefit waivers may be appropriate. Such a proposal should be based on market information about what employers and employees are interested in buying, detailed actuarial data on costs of different benefits to the target population, and public policy goals of encouraging coverage of selected services regardless of their cost impact. To facilitate employers' choices among plans and evaluate the price impact of foregone benefits, a waiver law should require, as do those in Illinois and Virginia, that insurers disclose to prospective purchasers the state's mandated benefits not covered in the limited plan and the premium savings associated with them.

Chapter VIII Comprehensive Strategies

Introduction

Most state access initiatives have focused on one or two of the public or public-private strategies described in early chapters. But a few states are attempting to enhance health care access for the majority of their populations by multi-faceted approaches that often combine public, private, and regulatory features, as well as publicly funded enhancements of the delivery system. This chapter profiles four states that have undertaken diverse steps to broaden access.

Although a number of states have considered or are considering universal, tax-based, single-payor systems, none has yet been enacted. The most comprehensive efforts, to date, continue to rely on work place private insurance for the majority, supplemented with public programs, incentives and public/private partnership efforts.

In addition to the states highlighted below, several other states undertook multi-pronged access strategies in 1990. For instance,

- Kentucky's employer insurance pool and tax credit discussed in Chapter V were part of a law that emphasizes access for residents of underserved areas. The statute increases Medicaid payments for physicians practicing in such communities and expands the use of mid-level practitioners working in newly established health care "networks".

- Delaware will begin to phase in a program of Medicaid expansions, medical insurance for general assistance recipients, and managed care for the uninsured using community health centers.

- Connecticut's law regulating the small group insurance market reform also expands Medicaid, establishes an outreach program for pregnant women and children, authorizes new insurance programs for low income children, pregnant women, and the disabled, provides grants for community health centers, and establishes low cost insurance for uninsured small firms.

The four states below are discussed in greater detail because their earlier start-up dates have allowed experience in developing and implementing their initiatives that may benefit other states. These bold initiatives are to be commended, especially in the light of the difficult fiscal and political realities states currently face. It is not clear, however, that they will achieve the objective of insuring access to all, or even most, of their populations.

All four states have recognized the importance of cost containment to the political acceptability and fiscal management of these efforts. Most express a preference for the use of

managed care plans, such as HMOs or PPOs to underwrite risk and deliver care. Some make use of other cost containment strategies such as provider discounts or utilization review. Nevertheless, all of these initiatives were undertaken in a period of economic growth and steady or growing state revenues, allowing a substantial new commitment of state dollars. In the current recession, with declining revenues, the new initiatives are in peril and cost containment measures take on added importance.

Some policy analysts argue that strategies to truly contain costs (rather than shifting costs to new payors or new segments of the health delivery system) can only be achieved through a single payor system with global price negotiation. In light of the current urgency regarding the development of effective cost containment strategies, this chapter includes a discussion of a New York proposal, not yet enacted, that links broadened access with the development of a single payor agency to control costs.

Hawaii

Hawaii has recently augmented its employer mandate with a publicly-subsidized insurance program for lower income residents. Since 1974 employers in the state have been required to provide hospital and medical insurance with statutorily defined benefits and cost sharing features to all full-time (20 hours/week or more) employees. Seasonal agricultural workers, students under age 21, government employees, public assistance recipients, self-employed individuals, and employees' dependents are exempt from the mandate. Employers must contribute at least half the premium for each employee (employees pay up to 1.5 percent of their wages toward the premium, but no more than half the premium). A public hardship fund is available for very small employers, but it has never been used. The law reduced the number of uninsured Hawaiians to a low of under 2 percent in 1977, but the number has increased in recent years, possibly due to more part-time or seasonal workers. The ERISA amendment authorizing the Hawaii employer mandate does not permit the state to modify that law, for instance by requiring coverage of part-time workers or dependents. Therefore the state developed an alternative to meet the needs of its remaining uninsured population.

The Hawaii State Health Insurance Program (SHIP), enacted in 1989 and implemented in 1990, is designed to provide access to basic preventive and primary and limited secondary care. An HMO (Kaiser Permanente) and an indemnity insurer (Hawaii Medical Service Association, the Blue Shield organization)[1] underwrite SHIP policies, which are available to residents with incomes up to 300 percent of the federal poverty level on an income-based sliding scale. Families pay up to $160 per month per family under the current scale. The state expects to subsidize about 80 percent of the average premium. The benefits comprise inpatient and outpatient services, including well child, well adult, and maternity care. Physician care is limited to 12 visits per year and pre-approved hospitalization to five days per year. Outpatient services are subject to a $5 per visit copayment. The plan does not

[1] HMSA pays its entire provider network on a fee-for-service basis but is developing a PPO for the SHIP plan.

cover drugs, dental, or vision care. In the first four months of plan operation, about 4500 individuals were enrolled out of about 35,000 potentially eligible residents. Administrators attribute this success to a very broad community-based outreach effort.

Unable to expand its successful employer mandate, Hawaii has begun a broad publicly-subsidized basic benefits program designed to cover the self-employed, employee dependents, and the unemployed. Due to a strong, creative outreach effort, early experience suggests that the plan is well-received, though it will be important to learn how many of the uninsured are willing to enroll voluntarily and whether the state can afford the approximately $17 million in state funds needed to subsidize all its lower income uninsured residents as well as whether the limited benefits under SHIP will meet most enrollee needs.

As mentioned in Chapter III, Hawaii has earmarked part of its SHIP funds for care of the uninsured through community health centers. This feature adds a direct service component to a system that otherwise relies exclusively on insurance mechanisms to assure access. Even more importantly, this illustrates that a subsidized health care infrastructure may be required to assure access to primary care for the disadvantaged.

Massachusetts

In 1988 Massachusetts enacted the "Health Security Act," a series of programs designed to enhance health care access for most of its residents. The "pay or play" payroll tax for firms of six or more employees (with a credit for firms offering insurance) was described in Chapter V. The state pool to be funded by this tax (plus revenues from the hospital rate-setting system) will make insurance available to uninsured employed and unemployed state residents, using managed care plans. Massachusetts also enacted several public programs to supplement the pool. It revised the state's hospital rate-setting law, mandated that private insurers cover well child care, provided grants to community health centers, augmented its general assistance medical program, and expanded state-funded Medicaid eligibility for lower income pregnant women, people leaving welfare for work, disabled children, and uninsured disabled workers (who can "buy in" to Medicaid on an income-based sliding scale).[2] A second employer tax of 0.12 percent of payroll (up to $16.80 per employee per year) began in 1990 to fund insurance for recipients of unemployment compensation. For such recipients with incomes under 300 percent of poverty, this program will either buy COBRA continuation coverage or a limited benefit insurance package underwritten by the state and administered by an insurer. Colleges are also required to insure their students. Even firms of five or fewer employees that are exempt from the pay or play tax can participate in the state's current health insurance demonstrations (described in Chapter IV) and receive income tax credits for their insurance costs.

[2]Some of these Medicaid expansions were subsumed into the state's federally-matched Medicaid program when Congress extended eligibility for pregnant women and children in 1988 and 1989.

Massachusetts' strategy relies on work place insurance and the as-yet-undefined state pool to cover most of its residents. Its low income programs target limited categories of residents, and its demonstrations and tax credits for small employers will result in coverage for some, but not all. One of the major questions with regard to the Massachusetts strategy is the likely response of small employers to the changes. Because of cost and other barriers faced by employers of businesses with fewer than fifty workers (discussed in Chapter VI), many of these employers may find it advantageous (or their only option) to pay the tax rather than provide coverage. Businesses of five or fewer face even more extreme barriers and the tax incentives offered to them may be insufficient to increase coverage much in this sector.

Lack of movement toward work place coverage could result in a significant burden on the state pool. Policy makers in Massachusetts are this year considering regulatory reform options in the small group insurance market (see Chapter VI) to stabilize the market and expand coverage options for small employers.

As discussed in Chapter V, the future of the "pay or play" model depends on both the outcome of a current lawsuit and the success of political pressure to abandon the program before it begins. It will also depend upon the size of the fund generated by the tax and other sources and the state's ability to subsidize premiums for lower income residents and encourage a large and representative group of the uninsured to enroll in the state's pool plan. Part-time workers, employee dependents, and workers in small firms may not be assisted directly through employer plans under the design of the current tax. Nor are longer-term unemployed residents eligible for insurance through the unemployment insurance tax pool. The state pool must be able to subsidize insurance for these groups and be sufficiently appealing and inexpensive to attract most of the uninsured while remaining within the state's budget.

Oregon

Oregon's approach of augmenting public programs with incentives (and ultimately a "pay or play" tax on employers) is somewhat similar to that of Massachusetts. But unlike Massachusetts' patchwork of public programs, in 1989 Oregon's legislature explicitly assumed public responsibility for all families with incomes below the federal poverty level, while making employers responsible for their employees.[3] Employer insurance incentives include authority for small firms to buy low cost insurance (about $55 per month) from several carriers under the state pool plan and the income tax credit described in Chapter V. By offering a larger credit in its earlier years and by extending to subsequent years if certain numbers of previously uninsured people are enrolled in the state pool, the tax credit is designed to encourage early pool enrollment. Oregon has chosen a public pool to lower premium prices for small firms rather than regulation of the remaining small group private

[3] Although the program is described as dividing responsibilities between the state and employers, it is not clear from SB 27 and SB 935 whether the state or the employer is supposed to cover workers with incomes below poverty or whether the payroll tax will apply to low wage workers.

insurance market. Insurance offered through the state pool plan has thus far been one HMO and several traditional indemnity plans (whose prices are reduced by age-rating and raising cost sharing contributions rather than more creative benefit design, provider network, or other managed care strategies). Pool carriers can also deny coverage based on medical underwriting, though the hope is that rejected individuals can enroll in the state's high risk pool.

The proposed new Medicaid program has generated the most national attention because, while expanding eligibility for Medicaid to all people living below poverty (approximately twice the number now covered under Medicaid in Oregon), the law established a process by which a commission ranks covered benefits by priority "representing the comparative benefits of each service to the entire population to be served." The ranking will consider health benefits, costs, and consumer preferences regarding all the services the Medicaid program now covers. Services are to be provided through prepaid capitated health plans, to the extent they exist in the state, and providers are to be paid the costs of providing services. The commission will forward the priority list to the legislature to set the Medicaid budget based on the cumulative costs of services funded in their order of priority.

Depending on its overall budget commitment, the Legislature will have to decide where to draw the cut-off point, below which benefits will not be available to the Medicaid population. The bill's supporters have suggested that it is politically unlikely that funding could be set at an unreasonably low level and that overall health care funding for the poor will have to increase. But opponents of the law assert that the line may be drawn arbitrarily and eliminate important services that can benefit many people.

As currently designed, Oregon's program requires several types of Medicaid waivers: (1) agreement by the federal government to share in funding care for all residents under the poverty line (which includes both the lowest income non-categorical groups like single individuals as well as higher income groups well above the state's current medically needy income eligibility standard), (2) authority to eliminate some currently required medical services from the Medicaid program, and (3) freedom of choice waivers to permit enrolling all Medicaid beneficiaries into prepaid managed care plans. Congress and HCFA have been reluctant to grant waivers until the design of the service list and state budget are clearly defined.

The "priority-setting" bill brings important issues to public debate: the unspoken rationing of medical care that currently exists for the non-Medicaid poor, the need for more research and consensus on what services are effective, and the need for society to discuss how to allocate scarce public health care funds in the absence of definitive research or consensus. Nevertheless, the law also raises several questions of equity. The priority-setting process is initially aimed at the poor, although the state pool law requires insurance plans for small employers to "include substantially similar services recommended" and funded through the priority-setting process. Furthermore, the program does not treat all the poor equally, since it applies to only families and children, not the elderly, blind, and disabled that account for

almost half the state's current Medicaid budget. The state's response to this concern is that it already rations long-term care and that it would be difficult to re-define benefits for the elderly and disabled who have dual Medicare and Medicaid coverage. Another concern is the statutory exemption of uncovered services from malpractice liability. Although it may be logically necessary to encourage prepaid health plans to contract with the state, it raises further concerns about equity when only poor families are subject to this limitation.

Finally, the approach of ranking benefits based on average beneficial effects across a population ignores a fundamental reality of medical practice: while some medical care may be entirely useless or useful for only a few patients, most care is valuable for some individuals. Cardiac surgery and organ transplantation may save lives or enormously improve the quality of life for some people under specific conditions. These procedures can be cost-effective for some patients when compared with alternative therapeutic approaches, while for other patients, they may be entirely inappropriate or even harmful. A significant current challenge for medical care researchers and health professionals is to reach consensus on criteria by which patients who can benefit from a given service (by defined standards, including cost-effectiveness and personal and societal preferences) can have access to it, while those for whom benefits are minimal could be denied access (at least publicly funded access). Including criteria for when services should be available makes a simple list substantially harder to draft but the task is not impossible. Standards for utilization review decisions about whether certain treatments should be provided to certain patients would require a modest expansion of UR activities in many current Medicaid programs and might actually obviate Oregon's need to seek a waiver on the issue of benefits.[4]

Even without the controversy surrounding its "priority-setting" law, the Oregon program is unlikely to cover all the state's uninsured. The "pay or play" tax will not become effective if 150,000 formerly uninsured residents obtain insurance through the state pool. This represents an estimate of the number of uninsured workers in small firms (the target of the state pool), but is only a fraction of the more than 400,000 uninsured Oregonians. Thus the pay or play tax would not become effective if about 40 percent of the currently uninsured receive coverage through the pool. By design, the state would apparently be satisfied if most full-time employees of small firms receive insurance, omitting part-time workers, employee dependents, the uninsured, and workers in larger firms.'

It is, however, unlikely that the tax incentives and state pool will encourage enough voluntary insurance to meet the target of 150,000 newly insured employees by October 1993. Employers may not be fully aware of the subtle and complex signals sent by the tax credit

[4] In other words, the priority-setting process would become a standard-setting process to develop detailed guidelines on medical appropriateness and necessity, which the state could implement in a more global and sophisticated way rather than a list of services that are either covered or not covered entirely.

[5] Larger firms can be offered insurance under the pool as of July 1990 but do not receive an income tax credit for insurance costs.

and pay or play law. After a year and a half of operation, in late 1990 the state pool had enrolled about 3800 employees and 3200 dependents in 1730 firms and so seems unlikely to reach the goal of 50,000 by October 1991 (which triggers an extension of the income tax credit) or 150,000 in late 1993 (which would repeal the pay or play tax).

If the pay or play tax becomes effective in 1993, it is likely that more employees and dependents will become insured. But part-time workers and the unemployed may remain without coverage. Whether the revenue funded by the tax will be sufficient for the state to offer attractive and affordable insurance to uninsured workers and others is the same question the Massachusetts program will face. Healthy residents without work place insurance may choose to remain uninsured, depriving the pool of their premium contributions and narrowing the spread of risk, while sicker residents may self-select into the pool and drive up premiums.

Maine

Over the past four years, Maine has taken an incremental approach to covering several groups of the uninsured. Its focus has been incentives for small firms and low wage workers, children, and the unemployed to enroll in private or public insurance programs. In 1989 the state began enrolling employees in small firms in an HMO under its MaineCare plan, described in Chapter IV, with subsidies for workers and families with incomes under 200 percent of the poverty line. In the same year, the state implemented a High Risk Insurance program to provide coverage for those with "uninsurable" medical conditions (including subsidies for low income subscribers). The following year the state implemented the Maine Health Plan (described in chapter II) to subsidize either public or private insurance for very low income children and adults. This program has both a Medicaid "buy-in" feature where individuals can receive services from any Medicaid participating provider at Medicaid rates, and a "buy-out" feature, where eligible employed workers will receive coverage through their employer's plan at the state's expense. To help assure provider participation, the state accompanied the implementation of the Maine Health Plan with a substantial rate increase for providers.

Maine's legislative package also included a relief fund for hospitals especially hard hit by bad debt and short-falls in Medicare reimbursement. The level of funding for this program, administered by the state's hospital rate-setting commission, is tied to expenditures under the Maine Health Plan. For every two dollars allocated to expanded coverage through the Maine Health Plan, one dollar will be appropriated for the hospital program. Both programs are funded through the state's general revenues. In addition, Maine instituted a community grants program (discussed in Chapter III) to encourage the development of preventive and primary health care services in underserved areas.

Recognizing that a large share of the state's uninsured work in small firms that have great difficulty entering and remaining in the small group insurance market, in 1990 the state also enacted one of the nation's first small group insurance regulation laws. This statute

(discussed in Chapter VI) regulates renewal rate increases, limits pre-existing condition exclusion waiting periods, and requires a successor carrier to credit enrollee satisfaction of a previous carrier's waiting periods. The waiting period limitations apply to successor group policies and to individuals joining group plans who have had prior continuous group or individual coverage (including coverage under public programs such as Medicaid).

Unlike Hawaii, Oregon and Massachusetts, Maine has chosen not to use employer taxes to extend work place coverage, but rather is relying on positive incentives and voluntary participation. Its hospital fund is one of the few state initiatives that explicitly addresses the cost-shift of bad debt to third party payors and attempts to contain health benefit cost increases by reducing this cross-subsidy. As such, it may be the only program trying to address the reduction of current employer coverage at the same time that coverage is extended to the currently uninsured. Similar to Connecticut, Maine has also recognized the importance of small group insurance regulatory reform as a part of a voluntary approach to encourage employer-based insurance. Its small group regulation does not, however, go as far as that in Connecticut which mandates guaranteed issue coverage and establishes a mechanism to spread the costs of the higher risk cases that may now be covered.

It is unclear how many workers and families will be covered by Maine's small firm insurance pilots. The first urban site is projected to enroll about 10 percent of employees and dependents of small firms in its geographic area within two years. As we have discussed in Chapter IV, the success of voluntary employer strategies is modest, even with substantial direct and indirect public subsidies. And by design these models omit the unemployed and seasonal workers that are either ineligible due to insurer or employer restrictions or unable to pay their share of the premium. The state has experienced overwhelming interest in the Maine Health Plan for low income children and adults since enrollment began in fall 1990, but this plan has not instituted managed care provisions to contain costs. Whether the state can afford to subsidize a substantial proportion of its over 100,000 uninsured residents through wholly publicly funded programs during recurring economic slumps seems unlikely.

Cost Containment Strategies

To date there are three basic strategies recognized for controlling overall health care costs:

- Buying only necessary or appropriate care (as Oregon is attempting to do and as many states and private purchasers do through utilization review of hospital, drug, and other benefits).

- Using managed care delivery models with a gatekeeper physician who refers to other services and manages a patient's overall care (as many state Medicaid, private purchasers, and public-private partnerships do).

- Health care provider budget control (setting overall hospital, physician, and other provider budgets, as some states have done through hospital rate-setting).

While waiting for more sophisticated clinical practice standards to guide both exterior utilization control processes and managed care delivery systems, governmental and private purchasers are apparently renewing interest in all-payer rate-setting strategies (Kosterlitz, 1991). Hospital rate-setting has reduced expenditures in some states (Merrill, 1986), but only Maryland is still authorized to include Medicare in its rate-setting programs.

New York officials are developing a proposal to link access with cost containment (Beauchamp and Rouse, 1990). UNY*Care would subsidize preventive care to all children and primary care for lower income families and would encourage employers to insure their workers through a pay or play tax. Insurers would be prohibited to underwrite or exclude pre-existing conditions from coverage. The program would lower insurance cost in two ways: (1) state reinsurance of inpatient and outpatient claims over $25,000 each, and (2) a public agency acting as both a broker to negotiate hospital and physician rates and a fiscal intermediary to pay all provider claims. This approach has the advantages of linking access and cost containment and creating a single payer (to reduce administrative costs) while building upon the existing private employer and insurer system. The plan is the next logical step in New York's strong tradition of health care regulation, though it is not clear that other states would find this model feasible.

Conclusion

The few states that have adopted broad initiatives to cover most of their residents are providing vital laboratories to test health care financing, delivery, and incentive models. Despite bills in several states in the past few years, no state has yet enacted a Canadian-style publicly-financed system. Instead, states that have moved ahead on health care access hope to achieve insurance coverage for most of their residents by a combination of public subsidy programs, employer incentives (including strong tax incentives), and small group insurance regulation along with delivery system enhancements. Some proposals are emerging that try to couple payment features of publicly-financed systems with the mixed public/private insurance and delivery systems already in place in the states.

It seems unlikely that these pioneering efforts, assuming they survive legal, political, and fiscal challenges, will completely meet the needs of the states' uninsured populations. Each of these programs, although bolstered by tax incentives and, in some cases, penalties, relies on voluntary participation by individuals and employers, some of whom may choose not to participate. In addition, several continued gaps in the health care safety net may become more evident. Although most of the comprehensive state programs include funding to enhance the delivery system in medically underserved areas, the heavy emphasis on insurance mechanisms may leave hard to reach populations such as the homeless and those in severely underserved inner-city areas without access to care. Further, the continued reliance on employer-based coverage leaves low and moderate income part-time, seasonal and

transitional workers in a continued marginal status - not quite eligible for employment-based coverage, but not necessarily eligible for publicly-funded programs. Finally, although many states have invested substantially in developing and testing new insurance products and regulatory strategies in the small group market, these efforts are still in the early stages of development. Until broad-based rating reform and mechanisms to reduce or subsidize costs are widely available, it is probably unrealistic to expect substantial shifts toward insurance coverage among workers and their dependents in small businesses. While states attempting universal coverage have for the most part committed to (or at least recognized the need for) publicly subsidizing those below the federal poverty level, they are clearly not fiscally able or politically prepared to broadly subsidize the moderate income population in the small group market whose current relationship to employer-based coverage is tenuous and sporadic.

Nevertheless, the states that are attempting comprehensive access strategies have accomplished two important and laudable goals. First, they have responded to a crisis, overcoming political and fiscal obstacles, in a manner that is meeting an immediate and pressing public need for access to health care. Second, they are leading the way both for other states and for federal policy makers in developing and testing ideas that may ultimately be part of a national solution to the health care access crisis. Particularly as the nation faces renewed and severe budgetary constraints, it is important that those state "laboratories" for health system development be encouraged, supported and closely monitored.

APPENDIX I

Summary Tables of State Access Initiatives

TABLE A

Summary of State Access Initiatives

STATE	RISK POOL	PUBLIC EXPANSION	PUBLIC/ PRIVATE COLLABORATION	PRIVATE SECTOR ACTIVITY	INSURANCE REFORM	INCOME TAX CREDIT
Alabama			SB	CF		
Alaska						
Arizona			SB			
Arkansas						
California	X	P C MBO				X
Colorado	X	CB	SB			
Connecticut	X RO	PC	SB IS		SGR	
Delaware						
D.C.						
Florida	X	DEM/CB	SB		MBW	
Georgia	X					
Hawaii			IS			
Idaho						
Illinois	X				MBW	
Indiana	X					
I o w a	X			CF		

STATE	RISK POOL	PUBLIC EXPANSION	PUBLIC/ PRIVATE COLLABORATION	-P RIVATE SECTOR ACTIVITY	INSURANCE REFORM	INCOME TAX CREDIT
Kansas				CF	MBW	X
Kentucky					MBW	X
Louisiana	X					
Maine	X	DEM/CB-MBO-GL	SB		SGR	
Maryland				CF		
Massachusetts		DB	SB IS P/P			X
Michigan		DEM/CB	SB	CF		
Mississippi						
Missouri	X			CF	MBW	
Minnesota	X	CB/MBO				
Montana	X					
Nebraska	X					
Nevada						
New Hampshire					SGR	
New Jersey						
New Mexico	X					
New York		CB, MBO	SB IS	CF	SGR	
North Carolina				CF	SGR	
North Dakota	X			CF		
Ohio			SB IS	CF		
Oklahoma			SB		State Pool-MBW	X

STATE	RISK POOL	PUBLIC EXPANSION*	PUBLIC/ PRIVATE COLLABORATION	PRIVATE SECTOR ACTIVITY	INSURANCE REFORM	INCOME TAX CREDIT
Oregon	X	GL	SB P/P		State Pool-MBW	X
Pennsylvania				C F		
Rhode Island					MBW	
South Carolina	X					
South Dakota						
Tennessee	X		SB			
Texas	X					
Utah	X		SB			
Vermont		CB PC			SGR	
Virginia					MBW	
Washington	X		IS		MBW	
West Virginia						
Wisconsin	X	DB	SB IS			
Wyoming	X			CF		

KEY

Risk Pool:
- x Individual HighRisk Programs
- RO Reinsurance Organization for Small Group Market

Public Expansions:
- DEM Medicaid Demonstrations
- CB Children's Buy-In
- DB Disabled Buy-In
- MBO Medical Buy-Out
- PC Prenatal Care Expansion (State or privately funded)
- GL General Low-Income

Public/Private Collaboration:
- SB Includes Small Business Program
- IS Individual Subsidy

Private Sector Activity:
- CF Caring Foundation

Insurance Reform:
- SGR Small GroupMarket Regulation Reform
- MBW Mandated Beefit Waiver

*Public expansions does not include state activity to adopt optional and mandatory Medicaid categories

TABLE B

Business Income Tax Credits for Health Insurance Purchases

State	Effective Date	Maximum Firm Size	Uninsurance Period	Minimum Employer Premium Share	Amount of Credit/Month	Maximum Years Available	Other
California	1/92	<26		75%	$25 or 25% (for employees & dependents)		Benefits must at least equal those in law
Kansas	1/92	<25 Uninsured Employees	2 years	75%	$25 or $50 (declines over 5 years)	5 years	
Kentucky	1/92	<51	3 years	50%	20 % (declines over 5 years)	5 years	Employers must participate in local insurance trust
Massachusetts	1/90	<50	3 years	50%	20% - Year 1 10% -Year2	2 years	
Oklahoma	7/90	Any size	Before 5/90	50%	$15	2 years	Employers must participate in state pool Plan
Oregon	7/88	<25 Uninsured	2 years	25%	$25 or 50% (declines over 5 years)	5 years	Employers must participate in state pool Plan

TABLE C

Small Group Alternative Insurance Benefit Laws

State	Bill Number	Firm Qualifications	Benefits Waived	Benefits Required (*new benefit)	Other
Florida	HR 3139 (1990)	<25 employees with salaries < 150% of poverty line, uninsured > 12 months	•RN midwives *Newborns > 18 months • Well-child services *Mammography ● Ambulatory surgery centers *Acupuncture *Home health care *Providers: Chiropractors, DDS, podiatrists, optometrists		Pilot through 1994
Illinois	HB 3528 (1990)	<26 employees, uninsured > 12 months	•Organ transplants *Optometrists *Mental health *Sexual abuse testing *Breast prosthesis or reconstructive surgery *Insurance conversion for spouses •Group insurance continuation	*Newborns *Mammography *Adopted children •Well child services	Insurers must notify subscribers of waived benefits
Kansas	HB 2610 (1990)	< 25 employees, uninsured > 24 months; minimum employer premium contribution to be set by state board	*Providers: Optometrists, DDS, podiatrists, psychologists, social workers *Newborns *Substance abuse *Mental health *Group insurance continuation *Mammography •Pap smears		

State	Bill Number	Firm Qualifications	Benefits Waived	Benefits Required (*new benefit)	Other
Kentucky	SB 239 (1990)	No size limit	*Providers: Optometrists, chiropractors, DO, DDS *Newborns *Mental Health *Substance abuse •Long-term care	14 days inpatient room/board; >50% of MD inpatient charges	
Missouri	HR 998 (1990)	<50 employees uninsured or about to drop coverage	*Maternity for unmarried women ● Ambulatory surgery centers •Free choice of provider *Any provider licensed to render service *Complications of pregnancy *Genital organ coverage for both sexes *Substance abuse *Disabled adult/children		
Oklahoma	SB 346	Employer without insurance as of May, 1988	*Cosmetic surgery *Chronic fatigue treatment *Obesity remediation (These services are expressly waived in statute though not mandated by current law)	*Basic hospital and MD care *Limited mental health, substance abuse, Rx **Prenatal care *Can include kidney, cornea, bone marrow transplants	Coverage to be through state pool with multiple insurers
Oregon	s935, 1990	C 25 employees without insurance 24 months		*Benefits to be "substantially similar" to those under Medicaid priority-setting law	Coverage to be through state pool with multiple insurers

State	Bill Number	Firm Qualifications	Benefits Waived	Benefits Required (*New benefit)	Other
Rhode Island		<26 employees without insurance at least 3 months, uninsured >24 months	*Adopted children *Infertility treatment *Nurse midwife services	•20 days hospitalization ● o.p. and emergency care for life-threatening situations ● 6 MD visits for children c 1 •4 MD visits for others ● 20 home health visits *Maternity ● 20 psych. & substance abuse visits/days *Newborn screening ● Mamography and pap smears	Pilot through 3/93 Health care providers must advise patients if they feel medical care is necessary but not covered by Plan
Virginia	**SB 480 (1990)**	<50 employees, uninsured >12 months	*Providers: DDS, chiropractors, mental health counselors, psychologists, social workers, podiatrists, PT, ST, audiologists, optometrists *Mental health *Substance abuse *Defined cost sharing features	•30 days inpatient hospital •2 MD visits per year • *Prenatal care **Obstetrical care **Defined well-child visits *Prior authorization	sunsets 7/94; insurers must notify subscribers of waived benefits
Washington	**S480**	< 25 employees, currently uninsured	*Providers: RN, podiatrists, optometrists, chiropractors, psychologists, DDS *Substance abuse *Home health and hospice •Mammography *Breast reconstructive surgery *Prenatal diagnosis ● PKU therapy ● Neurodevelopmental therapy •TMJ treatment *Insurance continuation *Coordination of benefits *Mastectomy >5 years, insurance disqualification	*Hospital care •MD care *Obstetrical care *Newborn coverage *Adopted children ● Disabled children	

APPENDIX II

Summary Descriptions of Insurance Expansion Pilots

Alabama's BasiCare

Contact: Hugh Davis, Univ. of Alabama: 205-934-5713

A private sector coalition has developed an insurance product for small business in the Birmingham area, underwritten by an HMO, that offers the alternatives of medium-priced coverage through private physicians and hospitals or low-priced coverage through public health department clinics and hospitals.

Date Begun: 4/90

Enrollment as of 9/1/90: 288 people in 46 firms
Average firm size: 4.6 Average group size: 6.2

Benefits:

- limited benefits: 6 MD visits/yr, 10 hospital days/yr
- $8 copayment for outpatient visits
- covers prescription drugs with $3 copayment

Eligibility:

- any firm that did not offer insurance within previous 12 months and with 3 or more employees
- firms offering insurance to some workers can enroll if fewer than half their workers participate
- employee participation requirements vary with firm size
- no medical underwriting, but excludes people denied insurance within previous 2 years and pre-existing conditions for 12 months
- employers must contribute at least 50% toward employee premiums

Subsidy:

- no public subsidy

Plan Cost Containment Features: managed care, use of low cost providers, limited benefits

Rates:

- private option: $74/indiv, $186/family
- public option: $45/indiv, $111/family

Marketing:

- mail, radio
- HMO uses salaried sales staff

Health Care Group of Arizona

Contact: Gail Silverstein, AHCCCS: 602-234-3655

Using the state's network of Medicaid HMOs, HCG offers to small firms four insurance plans through two different HMOs in two urban and several rural counties.

Date begun: 1/88

Enrollment as of 9/1/90: 1749 people in 505 firms
Average firm size: 4.0 Average group size: 3.5

Benefits:

- employers can enroll in any of 4 plans offered by the HMO, ranging from a catastrophic plan and a first dollar plan with no stop loss to a comprehensive plan with minimal copayments

Eligibility:

- any firm that did not offer insurance withii previous 6 months with under 25 F-T workers
- no medical underwriting; preexisting conditions excluded for inpatient care 1 yr

Subsidy:

- no explicit state subsidy, but state negotiated reinsurance arrangements for plans, provides marketing assistance and collects premiums

Plan Cost Containment Features: managed care

Rates:

- Average premiums range from: $55 - $93/indiv(35), $180 - 298/family of 3 +

Marketing:

- mail, radio, TV, newspaper ads
- both in-house sales staff and independent brokers

Lessons:

- despite Medicaid experience, plans were reluctant to participate because of unknown risk
- good utilization experience is encouraging more plans to consider participation
- program does not address needs of lower income workers
- marketing to small businesses is difficult

Cobrado's SCOPE

Contact: Judy Glazner, Univ of Colorado: 303-399-5056

SCOPE is a low premium, managed care indemnity plan for small firms, first available in Denver metro area and now marketed in several other urban areas.

Date begun: August 1989

Enrollment as of 12/26/90: 660 firms, 6300 people (about 66% previously uninsured)
penetration rate: about 2% of the estimated 242,000 uninsured workers and dependents in small firms in Denver area
average firm size : 4.1 Average group size: 9.2

Local Economic Conditions: state's economy has been weak but is recovering

Benefits:

- typical indemnity benefits with no cost sharing for preventive services, $15 copayment for MD visits, $250 deductible + 50% coinsurance for hospitalization, 50% coinsurance for tests, outpatient surgery
- stop-loss - $2750

Eligibility:

- employers under 50 (including groups of 1), even if previously insured, who pay at least 25% of premium
- employees working at least 30 hrs/wk
- 75% of all workers must enroll
- fairly typical medical underwriting criteria and 6 month preexisting condition exclusion
- somewhat more lenient excluded industry list

Subsidy:

- no public subsidy (but low income enrollees would be eligible for partial write-off of their cost sharing through state's indigent care program)

Plan Cost Containment Features:

- managed care plan with negotiated fees for Exclusive Provider network

Rates:

- $52(35-yr old male), $72(35-yr old female), $149/family
- about 40% of market rates for other typical indemnity plans
- surcharge on groups of 1

Marketing:

- mail, TV, radio ads
- brokers trained by project and referred leads (dire&d first to uninsured firms, the main SCOPE target)
- costs about $60/enrollee

Lessons:

- price is critical factor
- limited benefits are attractive when price is critical
- insurance industry underwriting and exclusion practices limit insurance availability in this market

Florida Small Business Health Access Corporation

Contact: Ree Sailors, FSBHAC: 904-681-9914

A public non-profit corporation is a purchasing group that negotiated rates with an HMO and acts as a third-party administrator/intermediary between small employers and a health care plan. The state has spent $2.4 million over 3 years to develop and market the insurance product, about $700,000 of which subsidizes insurance premiums.

Date Begun: 5/89

Enrollment as of 9/1/90: 3011 people in 601 firms
Average firm size: 1.8 Average group size: 5.0

Benefits:

- 2 options offered by HMO: standard ($10 copayment) or high option ($5 copayment)
- typical HMO benefits; prescription drug option may be purchased in addition

Eligibility:

- firms in business at least 1 year, not offering insurance in last 6 months, and with under 20 employees working at least 17.5 hrs/wk
- employers must pay at least 50% of employee coverage
- all eligible employees must enroll in plan
- state conducts underwriting using liberal criteria; refers uninsurables to state high risk pool; no pre-existing condition exclusions

Subsidy:

- state has negotiated lower rates by limiting HMO's risk through reinsurance, paying to lower family premiums
- state also performs marketing, eligibility, and billing functions

Plan Cost Containment Features:

- managed care

Rates:

- $72 - $82/indiv(35), $199 - $226/family

Marketing:

- TV, radio ads
- state marketing staff oversees agent network

Lessons:

- government sponsorship is credible
- a subsidy was necessary to attract the insurance partner
- state should share risk with insurer but not bear entire risk
- local markets differ; local pilots are valuable
- creating and owning a buying group gives state considerable leverage to negotiate rates, underwriting criteria, industry coverage
- voluntary efforts have limited impact, but mandatory approaches must include insurance industry reform

MaineCare

Contact: Deborah Curtis, ME Bureau of Medical Services: 207-289-2674

The state has negotiated with an HMO to offer small group insurance in one urban site and is developing a managed care product for a rural site. The state spent $720,000 over 18 months to develop and market the insurance and has spent $214,000 on premium subsidies.

Date Begun: 12/1/89

Enrollment as of 9/1/90: 814 People in 271 firms
Average firm size 2.1 Average group size: 3.0

Benefits:

- standard comprehensive HMO benefits

Eligibility:

- any firm that did not offer insurance within previous 12 months with under 16 F-T employees
- employer must contribute at least 50% to employee and dependent coverage
- all employees must participate unless insured elsewhere
- coordination with state high risk Pool; 90 day preexisting condition exclusion

Subsidy:

- state pays employee's share of employees under FPL
- state subsidy declines from 100% to 200% FPL
- state also subsidizes up to 20% of employer's share for marginally profitable firms
- subsidy costs state $54/mo; state pays 40% of overall bill; 60% of enrollees are subsidized

Plan Cost Containment Features:

- managed care HMO
- state negotiated substantial hospital discounts

Rates:

- community-rated without age or sex tiers
- $92/indiv, $274/family of 3 +

Marketing:

- no paid ads

Lessons:

- good utilization experience
- lower wage workers are willing to contribute something toward coverage
- sliding scale premiums are important
- price is still a deterrent to some firms

Massachusetts "Phase-In" Health Insurance Pilots

Contact: Camille Escuaga, Dept of Medical Security: 617-727-8300

Under Massachusetts Universal Health Care law, the state was required to develop pools for small employers to buy insurance. But the state decided that such pools are already available and instead developed pilots to improve affordability by premium subsidies, subsidizing administrative and marketing costs, and state risk sharing with plans. The state has put $11 million in a reserve fund to support the pilots over 2 years.

Date begun: January 1990

Enrollment as of 12/90: 970 people in 108 groups; enrollment capped at 7750 among 5 plans

Benefits:

- comprehensive HMO benefits and standard PPO benefits

Eligibility:

- differs among 5 pilots
- generally firms under 25 employees, in business 1 yr, without insurance in previous 12 months, and paying a minimum share of premium
- employees working fewer than 20 hrs/wk generally not eligible
- individuals in 1 pilot eligible if uninsured 12 months and income under 300% FPL
- no medical underwriting or exclusions (state finances costs of uninsurables)

Subsidy:

- employer premium subsidies range from 5% to 14% of premium
- individual plan subsidies range from 80% to 100% of premium
- state reinsurers certain claims (e.g., between $10,000 and $100,000 or over $15,000) in certain pilots
- state pays for excess costs of uninsurables in certain plans
- no premium subsidy to PPO, but funds marketing, claims processing, administrative and case management services

Plan Cost Containment Features:

- managed care in all plans and risk sharing with HMOs

Rates:

- $124-140/individual, $293-380/family
- approximately market rates for large groups (15% to 25% below small group rates)

Marketing:

- plans develop their own marketing strategies, including direct mail

Lessons:

- slow enrollment due to slow employer decision-making
- tax credit does not appear to create an incentive to buy insurance

Michigan's Health Care Access Project: One-Third Share Plan
Contact: Vem Smith, MI Dept of Social Services: 517-335-5100

Michigan's "1/3 Share Plan" was a 2-site demonstration program to subsidize health insurance premiums for small firms. Originally designed for firms that hired former AFDC recipients, this condition was eventually dropped.

Date begun: May 1988

Enrollment as of 9/1/90: 1026 people in 189 firms
Average firm size: 4.0 Average group size: 5.4

Local Economic Conditions: recovering in rural Marquette County; poor in Flint

Benefits:

- firms could choose among 12 plan in market, but subsidy was based on cost of HMO in Flint and Blue Cross plan in Marquette County

Eligibility:

- firms not insuring in previous 2 years with some employees with low incomes (<200% FPL in Flint, < 185% FPL in Marquette) - no firm size limitation
- part-time and seasonal workers generally not covered
- plans use standard underwriting, 6 month preexisting condition exclusion for some groups

Subsidy:

- state would pay 2/3 of maximum premium for employees with incomes under 100% FPL and 1/3 for those between FPL and maximum income level (employer to pay 1/3 plus extra cost if chose higher cost plan)
- subsidy dropped to 25% after 12 months of enrollment
- 83 % of enrollees are subsidized
- average cost to state: $27.50/subsidized enrollee, $20/enrollee

Rates:

- $118/mo/indiv(35); $248/mo/family of 3 +
- subsidy brings average premium down to about 85% of market rates

Marketing:

- mail, PSA, personal contacts by local staff

Special Features:

- state negotiated hospital discount for Flint HMO that helped to lower rates premiums 84% of market rate

Lessons:

- despite low enrollment, projects are viewed locally as successful
- most employees offered enrollment did enroll
- Flint HMO utilization experience has been good - normal risks
- despite subsidy, 1/3 of firms that contact Flint office did not enroll due to cost (firms under 5 yrs old less likely to offer coverage)
- indemnity coverage in Marquette seen as expensive; underwriting disqualified many potential enrollees or made coverage unaffordable
- welfare recipient connection was difficult in Flint and dropped; this feature of program created a welfare stigma in Flint

New York State Health Insurance Pilot Programs

Contact: Margie Geiger, NY Dept of Health: 518-473-0566

New York is testing health insurance subsidies for individuals and businesses in 5 geographic areas. Insurers process eligibility, determine premiums, contract with providers. The state has appropriated $13 million from its uncompensated care hospital pool to fund the five pilots over 18 months.

Date begun: from May 1989 through January 1990; Scheduled to run through 12/93

Enrollment: 5900 as of December 1990
penetration rate: 41% of maximum 14,500 enrollees

Benefits:
- 4 HMOs and 1 EPO
- comprehensive benefits (do not include some state mandates, e.g. number of outpatient mental health benefits)

Eligibility:
- individuals uninsured since 1/1/88 with incomes under 200% FPL
- employers of under 20 employees without insurance since 1/1/88
- no excluded industries or medical underwriting (but some preexisting conditions excluded)

Subsidy:
- for individuals state pays 62% - 91% of premiums (individuals need not spend more than 24% of incomes on premium)
- for employers, state pays 50% of premium (regardless of employee income) and employer pays 50%

Plan Cost Containment Features:
- managed care in all plans and risk sharing with HMOs

Rates:
- $52 - $153/individual; $244 - $459/family (varies by pilot site)
- approximately market rates
- subsidy decreases individual rates up to 90% and employer rates 50%

Marketing:
- mailings by plans
- by community groups and non-profit agencies in one site

Lessons
- marketing much more demanding and costly than plans anticipated
- prohibiting participation of firms insured since January 1988 is too long a waiting period

Ohio Health **Care** for **the** Workiig Uninsured
contact: Terry Coleman, OH Dept of Health: **614-466-1097**

Ohio is pilot testing insurance models for low wage workers in 4 sites, 3 subsidized plans and 1 low cost catastrophic plan. The state has budgeted $1 million for FY 90 and $1.7 million for FY 91 to fund the pilots over 18 months.

Date begun: January to June 1990 thru June 1991

Enrollment was 505 people as of **10/1/90;** capped at 1000 in the subsidized plans and projected to be 1000 in **the** catastrophic plan.

Benefits:

- 2 **HMOs** with comprehensive benefits
- rural PPO with $200 deductible and **80/20** coverage
- catastrophic plan: $5000 deductible for major medical plan; choice of $175 or $250 "medical spending account" for routine medical and dental care and prescription drugs

Eligibility:

- 1 pilot = individual coverage for post-AFDC families without workplace insurance
- 2 pilots cover **firms** without insurance for 18 months with workers with incomes under 200% FPL
- catastrophic pilot covers **firms** under 100 employees without insurance for 18 months

Subsidy:

- former AFDC families pay premiums for individual plan on sliding scale; state pays up to 97% of premium; pays 93 percent on average
- HMO pilot: employer pays **$50/$100;** state subsidizes low-income workers' premium share
- **PPO** pilot: employer pays up to **½** premium (negotiated with state), employee and state share remainder

Plan Cost Containment Features:

- managed care in **HMOs** and PPO, risk sharing with **HMOs**
- high cost sharing for hospitalization in catastrophic plan; medical spending account not spent one year expands benefits the next year

Rates:

- HMO and PPO plans: **$100/individual, $300/family**
- catastrophic plan: **$54/individual** (under **30), $142/family** (estimated average employer premiums: **$90-120/employee)**

Special Features of Catastrophic Plan:

- primary care spending account is expected to cover 90% of needed medical and dental care
- although IRS rules prohibit refunding the unspent account, residual in accounts are expected to be used to improve benefit design in later years
- for expenses between the $250 and $5000, plan administrator will help enrollees obtain low interest loans from providers to pay off medical debts

Oregon Small Employer Health Insurance Pool Plan

Contact: Rocky Ring, OR Ins. Pool Board: 503-373-1692

In 1989 Oregon established its health insurance pool for small employers, which offers 6 plans, including 5 PPOs and 1 HMO. By law, the monthly premium is capped at $53/individual employee.

Date begun: April 1989

Enrollment as of 11/30/90: 1730 firms with a total of 7012 enrollees (3837 employees plus 3175 dependents)

Benefits:

- standard HMO and indemnity plan benefits
- to keep premiums within statutory $53 cap, plans adjust benefits, primarily by raising copayments and deductibles for older persons

Eligibility:

- firms under 25 employees without insurance for 2 yrs that pay up to $40/employee/month

Subsidy:

- firms in pool are entitled to tax credit of lower of $25/employee or 50% of premium for first 2 yrs; credit declines and terminates after 5 yrs.

Plan Cost Containment Features:

- high cost sharing
- managed care for all plans, risk sharing with HMOs

Rates:

- $53/mo/employee
- $28/mo net of tax credit

Marketing:

- state has distributed information through small employer trade associations
- state plans direct mail campaign in spring 1990

Lessons:

- low enrollment since not actively marketed in first year
- employers generally supplement the basic $53 benefit, paying on average $68/employee

Tennessee MedTrust

Contact: Bart Perkey, TN Assoc. of Primary Care Ctrs: 615-329-3836

A private sector community health center-based HMO with deep hospital discounts offers coverage to uninsured employers in Memphis.

Date Begun: 3/20/89

Enrollment as of 9/1/90: 806 people in 203 firms
Average firm size: 2.0 Average group size: 3.9

Benefits:

- standard comprehensive HMO benefits with $5 MD copayment

Eligibility:

- firms of any size that did not offer insurance within previous 3 months
- employee participation requirements vary by firm sire

Subsidy:

- no public subsidy
- substantial hospital discounts lower rates to 55% of market rates

Rates:

- $49/indiv, $131/family

Marketing:

- radio

Tulsa Health Option

Tulsa Health Option is a project of the Tulsa Chamber of Commerce that aggregated large and small businesses into a health insurance buying group to purchase PPO and HMO coverage at a single community rate (adjusted for enrollee age and sex) regardless of firm size.

Date begun: October 1986

Enrollment as of January 1990: 34,000 to 40,000 enrollees, 4,000 - 10,000 of whom are in small employer groups
penetration rate: 7 - 17%

Benefits:

- both plans had comprehensive benefits and limited cost sharing

Eligibility:

- firms of any size, but target was small firms
- medical underwriting of firms under 10

Plan Cost Containment Features:

- managed care for both plans; risk sharing for HMO

Rates:

- $75-$85 /individual, $185/family
- 70-80% of market rates

Marketing:

- mail, newspaper, radio campaign
- trained brokers staffed Chamber phones

Special Features:

- community rate among all firms regardless of size provides a cross-subsidy from large to small firms

Lessons:

- in this community, large firms are willing to subsidize smaller ones by aggregating experience of all businesses into one large group
- large business was convinced that it would save money otherwise spent on cost-shift
- THO brought to very small groups HMO coverage that was not sold at all before
- despite THO, 1990 Chamber survey found that 29% of firms not insuring reported price as reason

Utah Community Health Plan

Contact: David Barton, Intermountain Health Care Foundation: 801-973-9768

A private hospital-based HMO that includes community health centers and private physicians and discounted hospital rates is offering coverage to small employers.

Date Begun: 9/12/89

Enrollment as of 9/1/90: 1190 people in 211 firms
Average firm size: 4.7 Average group size: 5.6

Benefits:

- standard HMO benefits with $10 MD visit copayment
- $150/day hospital copayment
- preexisting conditions covered at 50% first year

Eligibility:

- firms that did not offer insurance for 12 months with under 20 F-T workers
- medical underwriting and industry exclusions

Subsidy:

- no state subsidy
- provider rate discounts bring price down to 40% of market price in area

Rates:

- $64/35-yr old male, $74/35-yr old female, $187/family of 4

Marketing:

- direct mail
- staff salespersons

Lessons:

- insurers in state fought HMO license for this project
- providers are willing to participate at substantial discounts, but only if plan's marketing efforts are not too successful

Washington's Basic Health Plan
Contact: Tom Kobler, BHP, 206-586-5332

The state subsidizes premiums for individuals to purchase care from contracting HMOs and PPOs in six sites. Enrollment does not come through the workforce. The state has appropriated $30 million over 2 years, most of which subsidizes insurance premiums.

Date Begun: 1/1/89

Enrollment as of 3/1/91: 20,000 people

Benefits:

- comprehensive HMO benefits with $5 copayment for MD visits, no copayment for preventive services
- no drug or mental health benefits

Eligibility:

- any resident with income under 200% FPL
- no medical underwriting, but preexisting conditions excluded 1 yr

Subsidy:

- state pays full premium for persons under 75% FPL; all others contribute on a sliding scale up to 75% of the premium at 175% FPL
- subsidy scale favors lower income persons
- state pays average of 82% of premium

Plan Cost Containment Features:

- managed care through HMOs, PPO

Rates:

- $95/indiv (35), $295/family 3 +

Marketing:

- low key marketing campaign

Lessons:

- individuals are willing to contribute to premiums
- plan to study whether businesses are dropping coverage, but no evidence so far
- program development took time
- subsidies are costly

Wisconsin Health Insurance Pits

Contact: Judith Fryback, WI Dept of Health & Social Service: 608-266-7384

Subsidizing lower wage workers in small firms without insurance and large firms with insurance unaffordable to the low wage worker are two of Wisconsin's insurance pilots.

Date begun: Noninsuring firm pilot: 2189 through 12/90
Insuring firm pilot: 10/89 through 12/90

Enrollment:

- Noninsuring firm pilot as of 10/1/90: 60 firms/215 subsidized enrollees
- Average firm size: 1.9, average group size: 4.1
- Insuring firm pilot as of 10/1/90: 20 firms/116 subsidized enrollees

Benefits:

- Insuring firm pilot: employers can enroll in any of 4 indemnity plans or 1 HMO approved by Insurance Commissioner as "comprehensive" (e.g. stop loss no greater than $1000/$2500)
- Noninsuring firm pilot: firms' current coverage (must be "comprehensive," not disease-specific)

Eligibility:

- Noninsuring firm pilot:
  - any firm that did not offer insurance within previous 12 months with under 20 F-T workers and at least one employee under 175% of FPL
    employer need not contribute to premium for employees to receive subsidy
- Insuring firm pilot:
  - workers under 175 % FPL working in firms with under 100 employees who were uninsured for at least 6 months and who cover all dependents

Subsidy:

- Noninsuring firm pilot:
  - up to 75% of premium on income-based sliding scale
  - subsidy favors buying family coverage
- Insuring firm pilot:
  - full employee share of employer insurance
  - average cost to state: $41/individual, $168/family, $147/enrollee

Rates:

- Average premiums: $73/indiv., $265/family (market rates)
- net of subsidy: $32/indiv., $97/family

Marketing:

- mail

Lessons:

- employers have taken a long time to return applications
- some employers haven't applied because they don't realize they are eligible for subsidy or aren't interested in applying since they see subsidy as helping employees not the firm or feel insurance rates too high, despite subsidy (which only assists some of their employees)
- state and insurer time to process applications has been lengthy
- need a local presence for local pilots
- hard to reach currently insuring firms and their uninsured employees

APPENDIX III

State Latitute Under ERISA

ERISA Pre-Emption and State Health Care Financing Initiatives: What Can a State Do?

States are acutely aware of the limitations imposed by the federal pension reform law ("ERISA") on their ability to regulate self-insured employee health plans. While difficult to chart a perfectly safe course through ERISA's murky waters, this memorandum outlines first, in general terms the latitude states have under ERISA, then more specifically the likely approach that a court would take when faced with an ERISA challenge to a state's attempt to provide tax incentives for employer-provided health insurance through either an income tax credits or the "pay or play" model adopted in Massachusetts. The second part of this paper is a detailed legal analysis of the case law underlying these policy conclusions that could be of use to state attorneys general and legislative staff in drafting tax incentive laws.

I. State Health Insurance Incentive Authority Under ERISA

A. The Bottom Line: What States Can and Can't Regulate under ERISA

- States cannot directly regulate employee health benefit plans.
- States cannot mandate that employers provide health benefits or insurance.
- States cannot impose premium taxes on self-funded plans or require them to participate in insurance pools for high risk or other individuals, although they can tax stop loss insurers.
- States can regulate insurers, including stop loss insurers, but cannot regulate self-funded plans, even those using stop loss insurance.

B. State Incentive Plans

1. Income Tax Credits

Offering an employer a credit against his/her business income tax liability is a fairly benign positive incentive. Six states (California, Kansas, Kentucky, Massachusetts, Oklahoma, and Oregon) have enacted these laws that provide a tax credit of $15 to $25 per employee per month for two to five years, usually for previously non-insuring small firms. To qualify for the credit employers are required to pay a minimum proportion of the employee and/or dependent premium. Oklahoma and Oregon also require employers to buy insurance from a state pool. In these states it may be argued that the tax credit laws, especially the one in California that defines benefits that health plans must cover to qualify for the tax, do in some sense "purport to regulate" the terms and conditions of employee benefit plans. By the same logic, they can also be said to "relate to" benefit plans, and they are certainly not subject to any statutory exemptions.

Under this line of reasoning, the tax credit laws would be pre-empted by ERISA unless **a court would find that their impact was "tenuous, remote, or peripheral. " Such an exception** is possible under the Firestone tests (discussed on page 10). It is arguable, for instance (despite contrary language in Standard Oil), that taxation and tax credits are traditional state functions (albeit subject to congressional pre-emption[1]). It is also likely, for example, based on

Massachusetts' and Oregon's experience thus far, that tax credits have little impact on employers' decisions to select a plan. But if, as seems likely, the purpose of the credit is to encourage employers to offer and finance employee basic health coverage, tax credit laws would seem to affect terms and conditions, benefits administration, and relationships among the various parties.

A court might accept the argument that tax credit laws do not purport to regulate health insurance but merely offer a reward for employers who meet certain standards. The outcome of a challenge to a given tax credit appears to depend upon the actual legislative purpose in enacting it, whether to influence health plan selection and employer contributions or merely to reward voluntary employer activity. But as a practical matter, the chance that such a case challenging tax credit laws would be filed is remote, since the only employers with standing or interest in the issue would be those ineligible for the credit, who are unlikely, given its small value and limited duration, to prosecute an expensive lawsuit.

2. Pay or Play Taxes

The strategy most likely to face an ERISA challenge is the "pay or play" tax-plus-tax-credit approach adopted in Massachusetts and, if voluntary insurance enrollment goals are not met by 1993, Oregon. The Massachusetts Restaurant Association filed such a suit against the state in late 1990 seeking an injunction against implementing the law in 1992 on the ground of ERISA pre-emption.[2]

There are certain differences between these two laws. As part of its "Health Security Act" of 1988, Massachusetts will impose an employer tax of 0.12 % of payroll, and its tax credit applies to any employer payment up to that amount for any health benefit plan, regardless of benefits covered or employer premium contribution. Oregon, on the other hand, describes its program as a requirement that employers offer employee health insurance or pay a tax equal to a given percentage of the cost of basic benefits for employees and dependents. The statute creates a pool through which employers can purchase insurance, but it appears that uninsured employees and self-employed individuals cannot participate. Although pay or play generally presents an incentive rather than a mandate, one may argue, as courts seem to do throughout the ERISA cases, that a state cannot do indirectly what it cannot do directly.

The Massachusetts law is the more easily defended, since it is arguably not a state law that "purports to regulate" employee benefit plans. What it purports to do is establish a state-funded health program for all residents, with a payroll tax as its primary revenue source. If an employer relieves the state of this health care financing responsibility, it is logical that the employer should receive a tax credit. The credit is not conditioned upon any definition of terms or conditions, such as benefit levels or employer premium contributions. Thus, even if one argued successfully that the law does purport to regulate benefits, under the Rebaldo, Lane, Martori, and Firestone analyses (discussed below at pages 6 and 10), its effects should be seen as too remote for pre-emption. For example, this law meets the second and third Firestone tests (incidental effect on the plan and not affecting relationships among the employer, the plan, and

employees) and could arguably meet the "traditional state function" test (which would appear to be less weighty in any event).

The Restaurant Association asserts that the tax law "relates to" the administration and content of employee health plans because employers are "compelled" to examine and re-evaluate their plans and modify or discontinue them to minimize or avoid the tax. However, the law actually only compels employers to pay the tax and on its face appears neutal with respect to whether employers pay or insure their workers. The outcome of this case, which only the U.S. Supreme Court can finally resolve, will depend on whether the courts take a technical or broad view of Section 514. Technically, the statute seems not to "relate to" employee health plans despite the fact that employers may re-evaluate their coverage in light of the tax credit. And employer taxes, while differing among states, have not yeat been held to contravene ERISA's concern for national uniformity of benefit plan regulation. But if the courts view ERISA's purpose is to pre-empt laws that have a practical impact on employer decision-making, the program will fail.

For these same reasons, however, the Oregon statute is somewhat harder to justify. On its face it resembles a mandate, essentially similar to the one invalidated in Standard Oil[3], and it has generally been marketed as such by its supporters. It is less clear in Oregon than in Massachusetts that the state plans to establish a public insurance program for all uninsured residents or how the tax revenues will be used. Although employers can apparently escape the tax by providing any benefits, without definition, it is harder to argue that this law does not purport to regulate employee benefits. If a court is less concerned with the structure of and public relations surrounding the Oregon law, however, it might at least apply the tests of peripheral impact. If it can be argued that the state is really only imposing a tax (against which a credit is appropriate for each business reducing the state's responsibility by insuring its employees), then the Oregon statute seems about as likely as that in Massachusetts to meet a test of remoteness, and it might similarly overcome an ERISA challenge.

While a pay or play approach therefore has a reasonable chance of withstanding an ERISA attack, it seems likely to do so best if:

- o The legislative purpose is clearly to establish a state health care financing program and any employer tax credit is justified because the employer is relieving the state of this financing burden;
- o The tax is set out in the law as a fixed dollar amount or percentage of payroll (which may include inflation adjustments), not calculated specifically as the cost of a particular benefit package (especially one to be defined later); and
- o The tax credit is not conditioned on any definition of acceptable levels of benefits, employer contributions, or other structural or administrative features.

II. Legal Analysis of State Health Care Financing Authority under ERISA

Enacted in 1974 as a response to pension fraud and mismanagement, the federal

Employees' Retirement Income Security Act, ERISA, 29 U.S.C. 1001 et seq. sets out a comprehensive scheme to regulate employee benefit programs, including requirements for: disclosure to employees; reporting to the federal government; eligibility, participation, and vesting; funding and fiduciary and management standards; and a federal insurance system to fund insolvent plans.

A. The ERISA Statute

The Act applies to "employee benefit plans," which includes both "employee pension benefit plans" and "employee welfare benefit plans." (29 U.S.C. 1102(1)) The latter term is defined as a plan or program established by an employer to provide, among other benefits, employees' medical care "through the purchase of insurance or otherwise" (29 U.S.C. 1002(1), (3)). The Act regulates employee benefit plans maintained by any employer engaged in commerce or in any business affecting commerce. Exempt from the Act's jurisdiction are plans operated by governments or churches or those "maintained solely for the purpose of complying with workmen's compensation, unemployment compensation, or disability insurance laws" (29 U.S.C. 1003(b)).

Although it applies to employee health plans, ERISA does not regulate their content except to require that they provide the opportunity for continuation of group rates to former employees and dependents, the so-called "COBRA" continuation requirement of P.L. 99-272 (1985). In view of this federal regulatory vacuum, one might assume that the states could regulate health plan content and relationships among plan participants. However, ERISA's pre-emption clause (section 514(a) of the Act) provides:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in 29 U.S.C. 1003(a) of this title and not exempt under section 1003(b) of this title (29 U.S.C. 1144(a)).
>
> Subsection 514(c)(2) defines the term "state" to include any state, political subdivision, or agency thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefits plans" (29 U.S.C. 1144(c)(2).

And subsection 514(c)(l) (29 U.S.C. 1144(c)(l)) defines "state law" to include "laws, decisions, rules, regulations, and other state action having the effect of law, of any state."

Subsection 514(b) (29 U.S.C. 1144(b)(2)) provides several exemptions from the pre-emption clause: state laws regulating insurance, banking, and securities; state criminal law; the Hawaii Prepaid Health Care Act; multiple employer welfare arrangements; Medicaid "secondary payer" laws; and domestic relations orders that, for instance, divide pension benefits among spouses. Of particular relevance to state health insurance regulation, the so-called insurance "saving clause" is further modified by the "deemer" clause that prohibits a state from deeming

that an employee benefit plan or trust is an insurer in order to bring it under state regulatory jurisdiction.

B. Judicial Interpretations of ERISA's pre-emption clause

Before the Supreme Court decided it first ERISA pre-emption case on the merits in 198 1, a number of lower federal courts worked their way through the law's cumbersome provisions in order to determine whether it pre-empted various state attempts to regulate health and other benefit plans.

To evaluate ERISA's impact on a state law, courts should examine several questions in turn: Is the program at issue an employee benefit plan? Do any of the jurisdictional exceptions apply? Is the state law at issue one that "purports to regulate" such plans? Does the state law "relate to" such plans? Do any of the pre-emption exemptions apply? While courts have addressed each of these issues, they have rarely examined them in a logical sequence. We will explore each question briefly, focussing particularly on the last three issues, which have the greatest relevance to state health employer health insurance incentive programs.

1. What is an Employee Benefit Plan?

The courts have found that virtually any program of employee benefits constitutes a "plan" for purposes of examining ERISA pre-emption. A notable exception is the Supreme Court's determination that a state law mandating employer-paid severance benefits when closing a plant did not require the employer to have "a plan" and was therefore not pre-empted by ERISA.[4] The Court looked to the language of ERISA and its legislative history (emphasizing congressional concern with uniformity of regulation to avoid conflicting state laws) to define a plan as one requiring an ongoing administrative program. Since health benefits programs meet that test, it is certain that they would constitute an employee benefit plan.

2. Does the Plan Come Within ERISA's Jurisdiction?

Exempt entirely from ERISA jurisdiction are employee benefit plans maintained by governments or churches or established for the purpose of compliance with state workers' compensation, unemployment compensation, or disability laws. The contention that an employer's health insurance program is exempt as disability insurance was first raised in Standard Oil of California v. Agsalud.[5] The District Court rejected this argument after analyzing the different purposes served by health compared to disability insurance. And in 1984, the Supreme Court held that to be exempt as a disability insurance program, an employer plan would have to be established "solely" to comply with state disability insurance law.[6] That is, the state could not regulate multiple-benefits plans under its disability law but could require employers to maintain separate disability programs, which would then be subject to state jurisdiction.

3. Does the State Law "Purport to Regulate" Employee Benefit Plans?

Although this definitional language in section 514 could have a profound impact on state attempts to encourage employer insurance, the Supreme Court has never interpreted it. Two Courts of Appeal, however, have used the language to reject ERISA pre-emption challenges. In Lane v. Goren[7], the court held that ERISA did not pre-empt the state fair employment commission's award of damages for racial discrimination against an ERISA trust because the state policy at issue did not purport to regulate the ERISA plan even though it affected the trust's assets. The court identified three tests that a statute must meet to be pre-empted. It must relate to employee benefit plans, not be subject to the pre-emption exceptions, and purport to regulate employee plans. The court said that for a state law to purport to regulate an employee plan, it "must attempt to reach in one way or another the terms and conditions of employee benefit plans," for instance by regulating disclosure, fiduciary responsibilities, or claims resolution.

In Rebaldo v. Cuomo' the Second Circuit Court of Appeals held that New York's hospital rate-setting law was not pre-empted by ERISA merely because it increased an employee benefits plan's cost of doing business. "Where, as here, a state statute of general application does not affect the structure, administration, or type of benefits provided by an ERISA plan, the mere fact that the statute has an economic impact on the plan doesn't require that the statute be invalidated." The court agreed with its colleagues in Lane that whether a state law purports to regulate employee benefit plans establishes a test separate and distinct from whether the law relates to employer plans or falls within the exceptions to pre-emption.

Both cases suggest that whether a statute purports to regulate benefit plans is an independent test of ERISA pre-emption. As a matter of statutory construction, this inquiry should precede the question of whether a law "relates to" a plan and, if so, whether pre-emption exceptions apply. As a practical matter, it seems that the courts will examine these issues simultaneously.

4. What is a State Law That "Relates to" Employee Benefit Plans?

The issue most often examined in ERISA pre-emption cases, especially those involving health plans, is whether the state law "relates to" such plans. Of particular relevance are two cases decided by California District Courts in 1977. In Hewlett-Packard v. Barnes' the court invalidated the state's prepaid health plan law (regulating primarily HMOs) insofar as it attempted to regulate self-funded employee health plans. The court held that the pre-emption clause prohibits any state or local action that "would affect" any employee benefit plan. It also rejected application of the insurance exemption to pre-emption, citing the "deemer" clause that prohibits states from claiming that self-insured firms are traditional insurers.

The same year, another judge in the same district invalidated Hawaii's Prepaid Health Care Act in Standard Oil. The Act required that all employers offer to full-time employees a health program meeting certain standards. When the state required in 1976 that employers cover a defined set of services for substance abuse, Standard Oil, which maintained a self-funded plan

that did not include this coverage, challenged the state law as pre-empted by ERJSA. The District Court first held that Standard Oil's plan was an "employee benefit plan" under the Act. It then rejected the state's contentions that the health insurance law was a "disability insurance law" exempt from the Act and that the law was an exercise of taxing power, since funding for health benefits was not paid to the state and since the employer contribution "does not enable the state to perform a traditional, essential public function." To be a tax, the employer's contribution must be "calculated according to a specific formula."

The court next examined Hawaii's argument that the law does not "relate to" Standard Oil's plan in the same way that ERISA does (regarding vesting, disclosure, funding, and reporting). That is, the state argued that since ERISA did not regulate the content of health plans, the state could do so, effectively urging a partial pre-emption of any direct conflict between ERJSA and state law but none where federal law was silent. Due to section 514's decisive language, the court felt unable to conduct the type of balancing of state vs. federal interests generally used when state and federal laws conflict. Although criticizing the blanket pre-emption of state laws in subject areas the federal law does not regulate ("apparently without a specific discussion of the need for such a step") and quoting Justice Brandeis on the value of encouraging state social and economic experimentation, the court nevertheless read the pre-emption clause broadly. Under its plain meaning, benefits requirements "relate to" plans as much as do financial and administrative requirements.

The court also discussed the legislative history of the clause, which was narrowed in conference committee. The Senate bill would have pre-empted only matters specifically covered by ERISA, and the House version would have pre-empted only state regulation on issues of reporting, disclosure, and fiduciary duties. But the conference agreement went further than either house to pre-empt all state legislation that relates to benefit plans, even in the absence of a direct conflict. Supporters of pre-emption, such as Senators Harrison Williams and Jake Javits, argued that such broad pre-emption would eliminate "the threat of conflicting and inconsistent state and local regulation" and "endless litigation.". "

Based on its decision in the Hewlett-Packard case, the Ninth Circuit affirmed the District Court's holding, rejecting Hawaii's additional argument that a state mandate turns the employer's private plan into an exempt government plan. The Supreme Court affirmed the case without opinion. After several years of negotiations, including attempts to authorize all state regulation of health insurance plans or, at least, the Hawaii act and other similar laws, in 1983 Congress adopted an exception to ERISA pre-emption for the Hawaii law.[11] But the exemption prohibits amendments after 1974, foreclosing, for instance, the requirement of substance abuse coverage at issue in the Standard Oil case.

With this background of activity in the lower courts, the Supreme Court decided its first ERISA pre-emption case, Alessi v. Raybestos-Manhattan, Inc.[12]. The Court held that ERISA pre-empted a state law prohibiting workers' compensation award from being offset against pension benefits even though the effect on pension benefits was indirect. The Court noted that "every action bearing on private pensions may encroach on areas of exclusive federal concern. "

The Court's next pre-emption case, Shaw v. Delta Air Lines,[13] involved a challenge to two New York statutes requiring pregnancy leave: the Human Rights Act (prohibiting employment discrimination on the basis of pregnancy) and the Disability Act, requiring disability leave for pregnancy. The court read the pre-emption clause broadly, stating that "relates to" means "having a connection with or referring to" an employee benefit plan. Thus the Court held that both state laws related to employee benefit plans and were pre-empted. In its most recent ERISA holding, FMC Corp. v. Holliday,[14] the Court reiterated its Shaw language, noting that the pre-emption clause is "conspicuous in its breadth. "

5. State Regulation of Insurance: The Insurance Exemption

Of all the exceptions to pre-emption under section 514, such as criminal or banking law, only the one for state insurance regulation would be likely to apply to health plan legislation. In 1977 the First Circuit Court of Appeals foreshadowed the Supreme Court's 1985 Metropolitan Life decision in Wadsworth v. Whalen". Third party administrators sued to enjoin the state of New Hampshire from mandating that all group health insurance include mental health coverage. Most of the plaintiffs administered plans that were funded at least partially by group insurance but that ultimately bore some of the underwriting risk themselves. Nevertheless, the plans claimed that they were not self-funded and the court agreed, finding that private insurers shared risk with the plans. The court held that the statute in question was a state insurance law, exempt from pre-emption, while acknowledging the apparent inconsistency of permitting states, through insurance regulation, to do indirectly what they could not do directly -- regulate employee benefits provided by self-insured firms.

The Supreme Court followed similar reasoning in interpreting the insurance law exemption to section 514 in Metropolitan Life Insurance Co. v. Massachusetts[16]. Employers and insurers challenged the state's mental health benefits mandate. The Court found that the law did relate to employee benefit plans but was exempt as a statute regulating insurance. Maneuvering its way through the statutory labyrinth, the Court observed, "While Congress occasionally decides to return to the states what it has previously taken away, it does not normally do so at the same time." It noted further, "We also must presume that Congress did not intend to pre-empt areas of traditional state regulation," such as laws regulating the contents of insurance contracts. The Court set forth three tests (derived from the McCarran-Ferguson Act) to determine whether an activity is the "business of insurance" that states may regulate: 1) the activity spreads risk, 2) the relationship between insured and insurer is an integral part of the activity, and 3) it is limited to entities in the traditional insurance industry. In Pilot Life Ins. Co. v. Dedeaux[17], the Court added another step to insurance exception analysis: whether the common sense view of the statute in question would suggest that it was an insurance regulation law. In that case, general common law remedies for fraud and breach of contract that were not specifically directed to the insurance industry failed this test.

Met Life establishes two classes of health insurance: plans funded through traditional insurers, where states can define benefits, as most have done, and the self-funded plans not subject to the 700-odd state health insurance mandates. With as many as half of working

Americans estimated to be covered through self-funded plans, some analysts express concern over whether these enrollees are adequately insured. While most self-insured firms appear to offer fairly comprehensive major medical benefits, self-funded plans are not subject to state continuation and conversion requirements (other than the 18-month COBRA continuation) and cannot be required to participate in state insurance pools for high risk uninsurable individuals[18].

Applying the reasoning in Met Life, the Sixth Circuit added an interesting wrinkle to the interpretation of the insurance law exemption, In Michigan United Food and Commercial Workers Union v. Baerwaldt[19], a health plan trust fund challenged the state's mandatory substance abuse coverage law. Plaintiff funds were self-insured with stop loss coverage (insurance for claims above a given level) from Occidental. Citing Met Life, the Court of Appeals held that mandatory benefits laws are insurance laws and that the stop loss nature of the insurance is irrelevant; stop loss insurers were required to offer the state's minimum benefits. The court did not discuss the indirect impact of this requirement on self-funded plans: Stop loss coverage will generally dictate the type of primary coverage a plan will offer, since they must mesh administratively.

Similarly, in General Motors Corp. v. California State Board of Equalization[20], the court held that ERISA does not prohibit a state from taxing insurance premiums of stop loss insurers (although they cannot tax health benefits costs of self-insured health plans) even if the taxes are calculated based not only on the stop loss premium but also on the costs for primary coverage by the ERISA plan itself (for which the stop loss carrier is not responsible). Despite the fact that the stop loss contract required the ERISA plan to pay the carrier's actual premium taxes and that the state's premium tax law would clearly appear to "relate to" the employee benefit plans, the court upheld the tax scheme, noting that insurance taxation is generally regarded as insurance regulation reserved to the states under the McCarran-Ferguson Act. Since Anthony Kennedy wrote this opinion before joining the Supreme Court, his broad reading of the insurance exemption might portend greater flexibility for states to regulate self-insured employers in the future.

On the other hand, in United Food and Comercial Workers v. Pacyga[21] and Moore v. Provident Life and Accident Ins. Co.[22], the Ninth Circuit held that ERISA pre-empted a state's anti-subrogation law as well as a state's common law cause of action for fraud and breach of an insurer's fiduciary duty. In both cases, ERISA plans held stop loss coverage from indemnity carriers. But the court found that the insurance exception did not apply. The Supreme Court upheld this line of reasoning in FMC Corn. v. Holliday[23] when it invalidated a state anti-subrogation law, noting that such statutes can "affect plan structure. "

What appears to distinguish these cases is that in Michigan and General Motors the state regulation was directed at the stop loss insurer (such as in the tax case or the minimum benefits case) whereas in Moore and United it was aimed directly at the self-funded firm.

6. State Laws Can Have "Peripheral Effects" on Health Plans

The pre-emption cases, especially those from the Supreme Court, illustrate a broad reading of section 514(a) and narrow interpretation of the its exceptions. Yet despite Alessi's language that pre-emption is "deliberately expansive" and prohibits even indirect effects, some courts have preserved a few areas for state regulation by citing the dictum in Shaw that some impacts may be "too tenuous, remote, or peripheral" to be pre-empted. While leaving open the possibility that state law can "affect" health plans but not "relate to" them under Section 514, the Supreme Court has not yet provided guidance on the meaning of this potentially expansive phrase.

The impact of the state employment discrimination law in Lane and the hospital rate-setting law in Rebaldo are examples of laws that had a small, peripheral, and therefore permitted impact on employee benefit plans. In a case similar to Lane, the Ninth Circuit also found only a remote effect on employee benefit plans. In Martori Bros v. James-Massengale[24], the court held that an Agricultural Labor Relations Board award of pay for bad faith employer negotiations that was based in part on the rate of hourly wages set forth in an ERISA plan was not pre-empted by ERISA. This court cited four types of state laws that would be pre-empted: 1) those regulating the types of benefits or plan terms, 2) those regulating reporting, disclosure, funding, or vesting, 3) those setting forth rules to calculate the amount of benefits to be paid, and 4) common law remedies for misconduct by an ERISA plan administrator. Whereas a state cannot regulate conduct that is part of the administration of an employee benefit plan, in this case, using the plan's wage rate as a measure of damages awarded for employer misconduct is not regulating the plan's administration.

State garnishment laws applying to pension benefits for alimony and child support and community property laws effecting distribution of pension benefits were upheld many years before the explicit domestic relations order exception to pre-emption[25] was enacted in 1983[26]. In Stone v. Stone[27], a state community property law was upheld against an ERISA challenge. The District Court said that section 514 was not intended to pre-empt any state law with "even the most tangential relationship to ERISA" and distinguished the health plan cases on the ground that community property laws were "more well established" than laws regulating employee health plans.

Similarly, a municipal income tax ordinance that did not recognize a tax deferred income plan and medical spending account as exempt from income for purposes of calculating the city's tax was upheld against an ERISA challenge in Firestone Tire & Rubber Co. v. Neusser[28]. Citing the "peripheral/tenuous" dicta in Shaw, the court found that the tax did not directly affect the administration of benefits under the plan. It cited three factors for a state law to meet the Shaw test: 1) it is a traditional exercise of state authority, 2) it affects relations only between an outside party and either the employer, the plan, the fiduciary, or employees, rather than relations among the four parties, and 3) it has an incidental effect on the plan.[29] The court noted that the tax in question met all three tests but that the weight given to each test might vary under other circumstances.

Although it would be comforting for states attempting to design employer health

insurance incentive strategies to rely on the language in Shaw, it may be unwise. In Pilot Life the Supreme Court reiterated its position that section 5 14 is "not limited to state laws specifically designed to affect employee benefit plans. " And the lower courts, which have crafted pre-emption exceptions using both the Shaw language and the "purport to regulate" test, have in the past interpreted ERISA's scope narrowly, for instance on issues of pregnancy discrimination laws, only to be later overruled.

7. State Tax Laws

Because taxation is a long-standing state power, the district and circuit courts in Standard Q&suggested that a specific state tax law might circumvent ERISA pre-emption. However, a Connecticut tax directly on employee benefit plans, not a generally applicable tax, was invalidated in National Carriers Conference Committee v. Heffernan[30]. And state laws attempting to assess self-funded plans for the losses of state uninsurable risk pools have also been overturned[31].

The 1983 ERISA amendment that exempts the Hawaii health insurance law specifically provides that "nothing [in this subsection] shall be construed to exempt . . . any state tax law relating to employee benefit plans" (29 U.S.C. 1144(b)(5)(B). Due to both its placement in the law and its lack of legislative history to the contrary, this provision appears to relate only to a Hawaii tax law (perhaps because of the language in Standard Oil). By negative inference, therefore, the statute could be constructed specifically not to prohibit another state to use a tax law of general applicability, even though it relates to employee benefit plans. More likely, however, a court would consider many factors, including the significance of the impact upon benefit plans, in evaluating the impact of ERISA on a state tax scheme.

III. Conclusion

It is difficult to predict how a court, especially the Supreme Court, will resolve an ERISA challenge to a state health care insurance/financing incentive strategy such as a pay or play statute or tax credit. The pre-emption clause itself raises thorny policy problems, such as how states can effectively meet residents' needs for health care. Even absent this policy concern, the statute is fraught with internal inconsistencies: The exemption from all ERISA regulation of disability insurance and workers' compensation creates for multi-state employers the very chaos that the pre-emption clause was drawn broadly to avoid. And the insurance law exemption is inconsistent with a preeminent concern about uniformity of regulation. Despite state policymakers' concerns, it seems unlikely that Congress will amend ERISA to provide more state regulatory authority.

The Supreme Court's most recent ERISA holding should not discourage states from forging policy in this uncertain legal environment. A statute will be most likely to survive judicial scrutiny if, on its face, it not purport to and in fact does not regulate the benefits,

financing, or administrative terms of health plans. Thus, it is harder to defend a tax-plus-credit plan where the credit is conditioned on certain benefits or employer contributions. While advocates and analysts may worry about the kind of plan that employers might offer to avoid the tax, the tax amount will have to serve as both a sufficient revenue source for the state to finance care to the uninsured and a proxy for an adequate employer benefit plan.

Endnotes

1. See Aloha Air Lines v. Director of Taxation (464 U.S 7 (1983).

2. Massachusetts Restaurant Association v. Hooley, Superior Court Dept CA No. 90-7438, 12/7/90.

3. "All employers who have not provided employee and dependent health care benefits ... by **January** 1, 1994 shall make monthly payments to the fund..." Section 7 of Oregon Senate Bill 935 (1989).

4. Fort Halifax Packing Co.Inc. v. Coyne, 107 S. Ct. 2211 (1987).

5. 442 F. Supp. 695 (N.D. Cal. 1977) aff'd 633 F. 2d 760 (9th Cir. 1980), aff'd mem. 454 U.S. 801 (1981).

6. Shaw v. Delta Air Lines, 463 U.S. 85 (1983).

7. 743 F.2d 1337 (9th Cir. 1984).

8. 749 F.2d 133 (2d Cir. 1984), cert. den. 472 U.S. 1008 (1985).

9. 425 F. Supp. 1294 (N.D. Cal. 1977), aff'd 571 F. 2d 502 (9th Cir. 1978).

10. 120 Cong. Rec. 299942, 29993 (1974).

11. 29 U.S.C. 1144(b)(5).

12. 451 U.S. 504 (1981).

13. Supra note 6.

14. FMC Corp. v. Holliday, U.S.S.Ct #89-1048, Slip Op. at 5, November 27, 1990.

15. 562 F. 2d 70 (1st Cir. 1977).

16. 471 U.S. 724 (1985).

17. 481 U.S. 41 (1987).

18. St. Paul Electrical Workers v. Markham, 490 F. Supp. 931 (D. Minn. 1980), General Split Corp. v. Mitchell, 523 F. Supp. 427 (D. Wis. 1981), Dawson v. Whaland, 529 F. Supp. 626 (D. N.H. 1982).

19. 767 F.2d 308 (6th Cir. 1985).

20. 815 F.2d 1305 (9th Cir. 1987).

21. 801 F. 2d 1157 (9th Cir. 1986).

22. 786 F.2d 922 (9th Cir. 1986).

23. Supra note 14.

24. 781 F.2d 1349 (9th Cir. 1986).

25. 29 U.S.C. 1144(b)(7).

26. See, e.g., Cody v. Reider, 594 F. 2d 314 (2d Cir. 1979) and A T & T v. Merry, 592 F. 2d 118 (2d Cir. 1979).

27.450 F.Supp. 919 (N.D. Cal. 1979), aff' d 632 F.2d 740 (9th Cir. 1980), cert. den. 453 U.S. 922 (1981).

28.28. 810 F.2d 550 (6th Cir. 1987).

29. See also FMC Corp v. Holliday , supra note 14.

30. 454 F.Supp 914 (D. Conn. 1978).

31. See, St. Paul, supra note 18, Dawson, supra note 18, and General Split, supra note 18.

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